

05546

CERTIFICATE OF DEATH

05545

1. PLACE OF DEATH a. COUNTY <i>Prince Georges County</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) b. STATE <i>Prince Georges County Maryland</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i> 161	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cheverly</i>		c. LENGTH OF STAY IN 1b <i>D. O. A.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Prince Georges General Hospital</i>		d. STREET ADDRESS <i>4407 Inckerman Street</i>	
3. NAME OF DECEASED (Type or print) <i>Maurice</i> First Middle Last <i>(mni) Alsop</i>		4. DATE OF DEATH <i>Apr. 18</i> Month Day Year <i>1967</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov 28, 1897</i>
9. AGE (In years lost birthday) <i>69</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret. switchboard installer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>C & P. Telephone Co.</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Washington, D. C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Thaddens Alsop</i>		14. MOTHER'S MAIDEN NAME <i>Catherine Frank</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>Yes</i>	
17. INFORMANT <i>Andrey J. Alsop</i>		Address <i>4407 Inckerman Street, Hyattsville, Maryland</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Infarction</i> DUE TO (b) <i>Arterio-sclerotic Heart Disease</i> DUE TO (c) <i>Diabetes Mellitis</i>			INTERVAL BETWEEN ONSET AND DEATH <i>1 mth.</i> <i>6 yrs.</i> <i>8 yrs.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>June</i> , 19 <i>38</i> to <i>Apr. 18</i> , 19 <i>67</i> (that (I) (we) last saw the deceased alive on <i>Apr. 17</i> , 19 <i>67</i> , and that death occurred at <i>12:45</i> M, from causes and on the date stated above.			
22a. SIGNATURE <i>Charles C. Hageage</i>		22b. DATE SIGNED <i>Apr. 19, 1967</i>	
22c. PHYSICIAN'S NAME <i>Charles C. Hageage M.D.</i>		22d. ADDRESS <i>3308 Perry St. Mt. Rainier, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>Apr 22, 1967</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Port Lincoln Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>Prince Georges Co. Md.</i>
24. FUNERAL DIRECTOR <i>Clark E. Wisor</i>		25a. REC'D BY REGISTRAR <i>APR 26 1967</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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02070

THE UNIVERSITY OF CHICAGO
LIBRARY
540 EAST 58TH STREET
CHICAGO, ILL. 60637
U.S. DEPT. OF AGRICULTURE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05547

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05546

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forestville		c. LENGTH OF STAY IN 1b 6 Mo	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Regency Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Cyrus Field Armiger		4. DATE OF DEATH Month April Day 2 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 19, 1889
9. AGE (In years last birthday) 77 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John William Armiger		14. MOTHER'S MAIDEN NAME Virginia Wayson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 577-16-7709	
17. INFORMANT Roberta B. L. Plummer		Address Same as #2d	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and Shock DUE TO (b) Laceration of Wrist DUE TO (c) Mediastatic Carcinoma from Carcinoma of Lung. INTERVAL BETWEEN ONSET AND DEATH 15 Min			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Mediastatic Carcinoma from Carcinoma of Lung.			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Cut Wrist with Knife	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 10:30 PM m. 3/2/67		20d. INJURY OCCURRED While <input type="checkbox"/> Not White <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Regency Nursing Home		20f. (City or town) (County) (State) Same as #2	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe EXAMINER'S NAME (Type)		22. DATE SIGNED Apr 3, 1967	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/5/67	
23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d. LOCATION (City or Town) (County) (State) Washington D. C.	
24. FUNERAL DIRECTOR J. Wm. Lees Sons, 300 4th St. NE Wash., D.C.		25a. REC'D BY REGISTRAR APR 7 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION

2535

1234567891011121314151617181920212223242526272829303132333435363738394041424344454647484950515253545556575859606162636465666768697071727374757677787980818283848586878889909192939495969798991001011021031041051061071081091101111121131141151161171181191201211221231241251261271281291301311321331341351361371381391401411421431441451461471481491501511521531541551561571581591601611621631641651661671681691701711721731741751761771781791801811821831841851861871881891901911921931941951961971981992002012022032042052062072082092102112122132142152162172182192202212222232242252262272282292302312322332342352362372382392402412422432442452462472482492502512522532542552562572582592602612622632642652662672682692702712722732742752762772782792802812822832842852862872882892902912922932942952962972982993003013023033043053063073083093103113123133143153163173183193203213223233243253263273283293303313323333343353363373383393403413423433443453463473483493503513523533543553563573583593603613623633643653663673683693703713723733743753763773783793803813823833843853863873883893903913923933943953963973983994004014024034044054064074084094104114124134144154164174184194204214224234244254264274284294304314324334344354364374384394404414424434444454464474484494504514524534544554564574584594604614624634644654664674684694704714724734744754764774784794804814824834844854864874884894904914924934944954964974984995005015025035045055065075085095105115125135145155165175185195205215225235245255265275285295305315325335345355365375385395405415425435445455465475485495505515525535545555565575585595605615625635645655665675685695705715725735745755765775785795805815825835845855865875885895905915925935945955965975985996006016026036046056066076086096106116126136146156166176186196206216226236246256266276286296306316326336346356366376386396406416426436446456466476486496506516526536546556566576586596606616626636646656666676686696706716726736746756766776786796806816826836846856866876886896906916926936946956966976986997007017027037047057067077087097107117127137147157167177187197207217227237247257267277287297307317327337347357367377387397407417427437447457467477487497507517527537547557567577587597607617627637647657667677687697707717727737747757767777787797807817827837847857867877887897907917927937947957967977987998008018028038048058068078088098108118128138148158168178188198208218228238248258268278288298308318328338348358368378388398408418428438448458468478488498508518528538548558568578588598608618628638648658668678688698708718728738748758768778788798808818828838848858868878888898908918928938948958968978988999009019029039049059069079089099109119129139149159169179189199209219229239249259269279289299309319329339349359369379389399409419429439449459469479489499509519529539549559569579589599609619629639649659669679689699709719729739749759769779789799809819829839849859869879889899909919929939949959969979989991000100110021003100410051006100710081009101010111012101310141015101610171018101910201021102210231024102510261027102810291030103110321033103410351036103710381039104010411042104310441045104610471048104910501051105210531054105510561057105810591060106110621063106410651066106710681069107010711072107310741075107610771078107910801081108210831084108510861087108810891090109110921093109410951096109710981099110011011102110311041105110611071108110911101111111211131114111511161117111811191120112111221123112411251126112711281129113011311132113311341135113611371138113911401141114211431144114511461147114811491150115111521153115411551156115711581159116011611162116311641165116611671168116911701171117211731174117511761177117811791180118111821183118411851186118711881189119011911192119311941195119611971198119912001201120212031204120512061207120812091210121112121213121412151216121712181219122012211222122312241225122612271228122912301231123212331234123512361237123812391240124112421243124412451246124712481249125012511252125312541255125612571258125912601261126212631264126512661267126812691270127112721273127412751276127712781279128012811282128312841285128612871288128912901291129212931294129512961297129812991300130

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VR A15 (4)
20 M 1/66

CERTIFICATE OF DEATH

05548

05547

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 7 & 1/2 hrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS 4721 Hudson Ave.	
3. NAME OF DECEASED (Type or print) First Sally Middle Sarah S. Last Elizabeth Arnold		4. DATE OF DEATH Month April Day 3 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/2/99
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Tenna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert Lee Hatcher		14. MOTHER'S MAIDEN NAME Leanah Richardson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT William C. Arnold		Address 4602 Chelsea Ave. Suitland Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO (b) Coronary arteriosclerosis DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 3, 1967 , to April 3, 1967 , that (I) (we) last saw the deceased alive on April 3, 1967 , and that death occurred at 10:35M , from causes and on the date stated above.			
22a. SIGNATURE Edwin J. Jensen		22b. DATE SIGNED April 4, 1967	
22c. PHYSICIAN'S NAME (Type) Edwin J. Jensen, M.D.		22d. ADDRESS Prince Georges General Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/10/67	
23c. NAME OF CEMETERY OR CREMATORY Alex. National Cemetery		23d. LOCATION (City or town) (County) (State) Alex. Virginia	
24. FUNERAL DIRECTOR Robert E. Wilhelm ADDRESS 4308 Suitland Road, Suitland, Maryland		25a. REC'D BY REGISTRAR APR 6 1967	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

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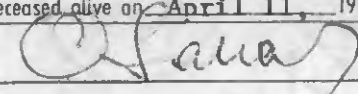
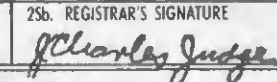
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05549

CERTIFICATE OF DEATH

05548

1. PLACE OF DEATH a. COUNTY Prince Georges		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 10 days		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 5906 Central Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital						d. STREET ADDRESS Capitol Heights					
3. NAME OF DECEASED (Type or print) First Middle Last Paul W Austin						4. DATE OF DEATH Month Day Year April 11 19 67					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 25 29 July 1929		9. AGE (In years last birthday) 37 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Asst. Mgr.				10b. KIND OF BUSINESS OR INDUSTRY Envoy Motel		11. BIRTHPLACE (County & State, or foreign country) Newark, N.J.				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank L. Austin						14. MOTHER'S MAIDEN NAME Gertrude C. Auger					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWII				16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Linda Lou Austin (above address)				Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease DUE TO (b) Multiple Thromboembolii - right lung DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (we) attended the deceased from Jan. , 19 65 , to April 11 , 19 67 , that (I) (we) last saw the deceased alive on April 11 , 19 67 , and that death occurred at 10:25 PM from causes and on the date stated above.											
22a. SIGNATURE 						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIR. <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED April 12, 1967			
22c. PHYSICIAN'S NAME (Type) Ohannes Sahakyan, M.D.						22d. ADDRESS Professional Bldg. Cheverly, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/15/67		23c. NAME OF CEMETERY OR CREMATORY Carthage Cemetery				23d. LOCATION (City or Town) (County) (State) California, Kentucky			
24. FUNERAL DIRECTOR Nailey's Funeral Home Inc.						ADDRESS Mt. Rainier, Maryland		25a. REC'D BY REGISTRAR APR 17 1967		25b. REGISTRAR'S SIGNATURE 	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CONFIDENTIAL

SECRET

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05550

CERTIFICATE OF DEATH

05549

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 106 Bellgreen Street				d. STREET ADDRESS 106 Bellgreen Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ESTHER Middle M Last BABCHAK				4. DATE OF DEATH Month April Day 30 Year 19 67			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 22, 1905	
9. AGE (In years lost birthday) yrs. 61		IF UNDER 1 YEAR Months Days Hours Mm.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (County & State, or foreign country) Virginia				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Robert Whited				14. MOTHER'S MAIDEN NAME Caroline Duncan			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO				16. SOCIAL SECURITY NO.		17. INFORMANT Andrew J. Babchak 106 Bellgreen Street	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO Cognitive Heart Failure CHD							INTERVAL BETWEEN ONSET AND DEATH 4 1/2
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4/22/67, 19 to 4/30/67, 19 that (I) (we) lost saw the deceased alive on 4/22/67 and that death occurred at 2:15 P.M. from causes on and on the date stated above.							
22a. SIGNATURE J. O'Donovan M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4/30/67	
22c. PHYSICIAN'S NAME (Type) J. O'Donovan				22d. ADDRESS 440 Ashland Rd			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-3-1967		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Suitland Maryland	
24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home 4308 Suitland Road Suitland Maryland				25a. REC'D BY REGISTRAR DATE MAY 3 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

203

07270

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05550

05551

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FORESTVILLE</u>		c. LENGTH OF STAY IN 1b <u>2 WKS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OXON HILL (WASH DC 20021)</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>RECENT NURSING HOME 7420 MARLBORO PIKE</u>				d. STREET ADDRESS <u>5216 COLONY ROAD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ann</u> Middle <u>CHRISTINA</u> Last <u>BAIER</u>				4. DATE OF DEATH Month <u>April</u> Day <u>1</u> Year <u>1967</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 27, 1888</u>	9. AGE (In years last birthday) <u>78</u> yrs	10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>		11. IF UNDER 24 HRS Hours <u> </u> Min <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TEACHER (RETIRED)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PUBLIC SCHOOLS</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MARLAN, IOWA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>(UNKNOWN)</u>		14. MOTHER'S MAIDEN NAME <u>NORGARD</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year of dates of service) <u>NO</u>			
16. SOCIAL SECURITY NO <u>504-09-9475A</u>		17. INFORMANT Address <u>EXON HILL, MD 20021</u> <u>ROLAND V. BAIER - 5216 COLONY ROAD</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> DUE TO (b) <u>Arteriosclerotic Heart disease</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.				INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>5 yrs.</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS ALTOPTYPY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (we) (this hospital) attended the deceased from <u>3-14</u> , 19 <u>67</u> , to <u>4-1</u> , 19 <u>67</u> that (we) (we) last saw the deceased alive on <u>4-1</u> , 19 <u>67</u> , and that death occurred at <u>9:02</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>W B Sheer</u>				22b. DATE SIGNED <u>4-1-67</u>		22c. PHYSICIAN'S NAME (Type) <u>WALTER B. SHEER</u>	
22d. ADDRESS <u>6400 MARLBORO PIKE SE. WASH DC</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>					
23b. DATE THEREOF <u>4-5-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>LAKE WOOD CEMETERY MINNEAPOLIS MINN</u>		23d. LOCATION (City or Town) (County) (State) <u>MINN</u>		23e. ADDRESS <u>W.W. CHAMBER CO - WASHINGTON DC</u>	
24. FUNERAL DIRECTOR <u>W.W. CHAMBER CO - WASHINGTON DC</u>		25a. REC'D BY REGISTRAR <u>APR 4 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

05552

05551

1 PLACE OF DEATH a COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b COUNTY Prince George's	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c LENGTH OF STAY IN 1b DOA	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		d STREET ADDRESS 6101 Kolb Street	
3. NAME OF DECEASED (Type or print) Samuel Thomas Bailey		4 DATE OF DEATH Month 4 Day 24 Year 1967	
5 SEX male	6. COLOR OR RACE negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 2-15-1888
9. AGE (In years lost birthday) 79 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER	
11 BIRTHPLACE (State or foreign country) South Carolina		12 CITIZEN OF WHAT COUNTRY? U. S. A.	
13 FATHER'S NAME Wylie Bailey		14 MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Mrs. Dessie K. McCoy		Address Farmmont Hts 1118-60th Ave. Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure 4200 DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH minutes over 4 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month Day, Year Hour a.m. _____ p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe M.D.		22. DATE SIGNED 4-24-67	
EXAMINER'S NAME (Type) John Kehoe, M.D.		Address (Street city, town, or county) Riverdale, Md.	
23a (URIAL) CREMATION, REMOVAL (Specify) H-29-67	23b DATE THEREOF 4-29-67	23c NAME OF CEMETERY OR CREMATORY Nat Harmony	23d LOCATION (City or Town) (County) (State) Highland Park Md
24 FUNERAL DIRECTOR H.S. Washington & Son		25a RECD BY REG STRAR APR 27 1967	
ADDRESS 4925 N. Anne Ave NE		25b REG STRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11/12/20



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1 PLACE OF DEATH a. COUNTY Prince George's Maryland										2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY Prince George's														
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly					c. LENGTH OF STAY IN ID DOA					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier														
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital										d. STREET ADDRESS 3151 Queens Chapel Road										e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3 NAME OF DECEASED (Type or print) First Middle Last Ann Elizabeth Barnes										4 DATE OF DEATH Month Day Year 4 21 67														
5 SEX female		6 COLOR OR RACE white		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH 3-9-23				9 AGE (in years last birthday) 44 yrs		10 IF UNDER 1 YEAR Months Days Hours Min		11 IF UNDER 24 HRS Months Days Hours Min										
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					10b. KIND OF BUSINESS OR INDUSTRY Own Home					11 BIRTHPLACE (State or foreign country) Virginia					12 CITIZEN OF WHAT COUNTRY? U.S.A.									
13 FATHER'S NAME Thomas Mercia										14. MOTHER'S MAIDEN NAME Florence														
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no					16 SOCIAL SECURITY NO 227 18 0037					17 INFORMANT Address Raymond H. Barnes Same as #2 (husband)														
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema 9702 DUE TO Acute barbiturate intoxication Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)															INTERVAL BETWEEN ONSET AND DEATH									
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)															19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH					20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Ingested overdose of barbiturates																			
20c. TIME OF INJURY Month, Day, Year am Hour a.m. 4 21 19 67 pm					20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc) Home					20f. (City or town) (County) (State) Mt. Rainier Pr. Geo Md.									
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																								
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe M.D., Riverdale, Maryland										CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)										22. DATE SIGNED 4-22-67				
23a. BURIAL CREMATORY OR REMOVAL (Specify) Burial					23b. DATE THEREOF 4/24/67					23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln					23d. LOCATION (City or Town) (County) (State) Colmar Manor P.G. Md.									
24 FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.										25a. REC'D BY REGISTRAR DATE APR 24 1967					25b. REGISTRAR'S SIGNATURE Charles Judge									

FOR STATE
HEALTH DEPT.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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VR A15ME (5)
6M 1/67

05554

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05553

1 PLACE OF DEATH a COUNTY Prince George's b CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) Cheverly c LENGTH OF STAY IN lb 3 days d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital			2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a STATE Maryland b COUNTY Prince George's c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 4703 41st Street d STREET ADDRESS Hyattsville e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3 NAME OF DECEASED (Type or print) Kenneth Barnes			4 DATE OF DEATH Month 4 Day 29 Year 1967		
5 SEX male	6 COLOR OR RACE Negro	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 7-4-12	9 AGE (In years last birthday) 54 yrs	10 UNDER 1 YEAR Months 1 Days 29
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRASH COLLECTOR		10b KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country) VIRGINIA		12 CITIZEN OF WHAT COUNTRY? USA
13 FATHER'S NAME HOWARD BARNES			14. MOTHER'S MAIDEN NAME LOUISE		
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO UNKNOWN	17 INFORMANT Address Mrs. LOUISE BARNES 4703 41st St. HYATTSVILLE, Md.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute subdural hematoma, right frontal lobe. 9039 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Laceration of right frontal lobe. DUE TO (c) Skull fracture, right posterior fossa.					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part II or Part I of item 18) fell and struck head on stone floor			
20c TIME OF INJURY Month, Day, Year Hour 6:00pm Min 11 4-26-67	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office, etc.) 4710 41st Place, Hyattsville, P.G., Md.	20f (City or town) Hyattsville	(County) Prince George's	(State) Md.
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John Kehoe		M.D. John Kehoe M.D., Riverdale, Md.		22. DATE SIGNED 4-30-67	
EXAMINER'S NAME (Type) John T. Rhine		Address (Street, city, town, or county) 3015 - 12th St., N.E. MAY 3 1967			
23a BURIAL, CREMATION, REMOVAL (Specify) 5-3-67	23b DATE THEREOF 5-3-67	23c NAME OF CEMETERY OR CREMATORY Harmony Memorial Park		23d LOCATION (City or town) Prince George's County	(County) Prince George's
24 FUNERAL DIRECTOR John T. Rhine		ADDRESS 3015 - 12th St., N.E.		25a REG'D BY REG. STRAR MAY 3 1967	25b REG. STRAR'S SIGNATURE Charles Judge

FOR STATE
HEALTH DEPT

05555

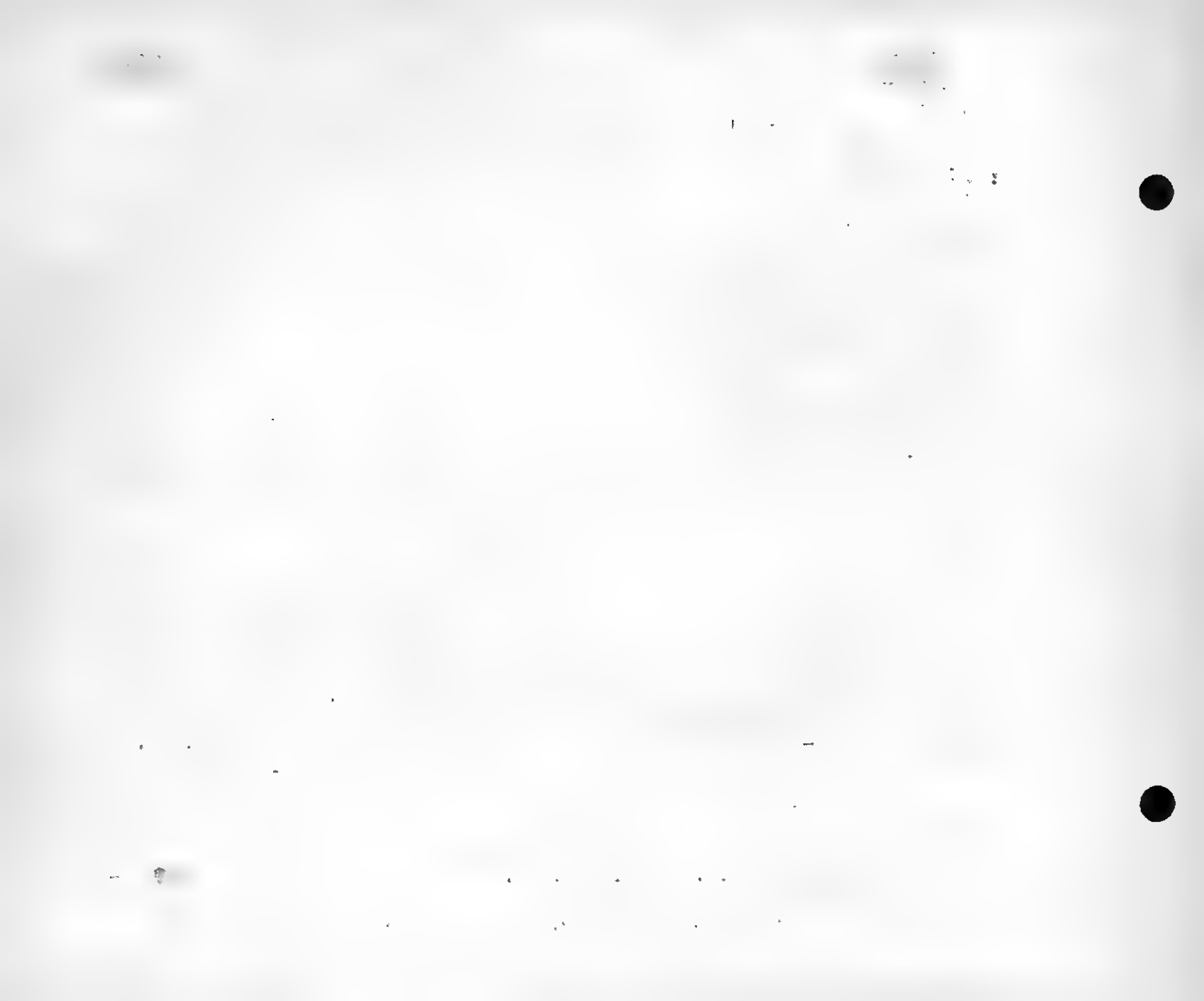
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05554

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bladensburg c. LENGTH OF STAY IN lb 2 days		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bladensburg d. STREET ADDRESS 5215 Newton Street e. US RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Dorothy Gail Baur		4. DATE OF DEATH Month 4 Day 4 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-29-1945
9. AGE (In years last birthday) yrs 21		10. IF UNDER 1 YEAR Months 4 Days 4 Hours 19 Min 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE, CLERK		10b. KIND OF BUSINESS OR INDUSTRY MONTGOMERY WARD	
11. BIRTHPLACE (State or foreign country) PENN'A.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME R. RUSSELL		14. MOTHER'S MAIDEN NAME AUDREY TAMBLIN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO UNKNOWN	
17. INFORMANT GERALD BAUR		Address 5401 JOAN LAKE TEMPLE HILLS MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Barbiturate intoxication DUE TO (b) 970.2 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Took overdose of barbiturates.			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Took overdose of barbiturates.	
20c. TIME OF INJURY Month, Day, Year Hour a.m. PM p.m. 4-2- 19 67		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Bladensburg Motel, Bladensburg, Md.		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		22. DATE SIGNED 4-4-67	
23a. BURIAL CREMATION REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4-8-1967	
23c. NAME OF CEMETERY OR CREMATORY MT. VERNON - CEM. VERSAILLES, PENN'A.		23d. LOCATION (County) (State) MCCONEEPORT (County) (State)	
24. FUNERAL DIRECTOR W. N. Chambers Co. Riverdale, Maryland		25a. REC'D BY REG. STRAR APR 10 1967	
25b. REG. STRAR'S SIGNATURE W. N. Chambers		25c. REG. STRAR'S SIGNATURE W. N. Chambers	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, at any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
05556						05555					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)					
a. COUNTY Prince Georges MARYLAND						a. STATE Maryland b. COUNTY Prince Georges					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 50 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital						d. STREET ADDRESS 3717 35th St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Vera Middle P. Last Beacraft						4. DATE OF DEATH Month April Day 18 Year 1967					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> Sep. DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH 24 Aug., 1930		9. AGE (In years last birthday) 36 yrs		10. IF UNDER 1 YEAR Months 36 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress				10b. KIND OF BUSINESS OR INDUSTRY Restaurant		11. BIRTHPLACE (County & State, or foreign country) Washington D. C.				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Clendening						14. MOTHER'S MAIDEN NAME Vera P Harrison					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no				16. SOCIAL SECURITY NO. 578 38 4431		17. INFORMANT Sandra L. Bennett 9445 Arlington Blvd. Fairfax, Va.					
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c))											
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hepatic Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) Cerebral Infarct DUE TO (c) Chronic Alcoholism										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that the (this hospital) attended the deceased from Feb. 27, 1967 , to April 18, 1967 , that we (we) lost the deceased alive on April 18, 1967 , and that death occurred at 12:45 AM from causes on and on the date stated above.											
22a. SIGNATURE B. Bahrami, M.D.						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 4/18/67			
22c. PHYSICIAN'S NAME (Type) B. Bahrami, M.D.						22d. ADDRESS Prince Georges general Hospital					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 4/20/67		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln				23d. LOCATION (City or Town) (County) (State) Colmar Manor, P. G. Md.	
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.						25a. REC'D BY REGISTRAR APR 24 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge			

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05557

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05556

1 PLACE OF DEATH a COUNTY Prince George's				2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a STATE MARYLAND b COUNTY Prince George's			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c LENGTH OF STAY IN 1b DOA		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillside		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital				d STREET ADDRESS 5286 Marlboro Pike			
3 NAME OF DECEASED (Type or print) Benjamin Bernard Bean				4 DATE OF DEATH Month 4 Day 9 Year 1967			
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input type="checkbox"/> D VORCED <input type="checkbox"/>	8 DATE OF BIRTH 5 Nov. 1900	9 AGE (In years last birthday) 66 yrs	10 IF UNDER 1 YEAR Months 9 Days 19 Hours 67 Min		11 CITIZEN OF WHAT COUNTRY? USA
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAINTER		10b KIND OF BUSINESS OR INDUSTRY CONTRACTING		11 BIRTHPLACE (State or foreign country) WASH. D.C.		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME BENJAMIN A. BEAN				14 MOTHER'S MAIDEN NAME EVA RICHARDSON			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWII		16 SOCIAL SECURITY NO 577-07-5760		17 INFORMANT ANNA C. BEAN Address SEE # 2			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure DUE TO Arteriosclerotic heart disease (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						INTERVAL BETWEEN ONSET AND DEATH minutes over 5 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes - over 1 yr., Gout - over 3 years.						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)		20c TIME OF INJURY Month Day Year Hour a.m. 19 p.m.		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.)		20f (City or town)		(County)		(State)	
21 I certify that I took charge of the removals described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe, M.D.				22. DATE SIGNED 4-10-67			
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.				Address (Street, city, town, or county)			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE THEREOF 4/13/67		23c NAME OF CEMETERY OR CREMATORY Alexandria Nat'l		23d LOCATION (City or town) (County) (State) Alexandria, VA	
24 FUNERAL DIRECTOR Chas. W. Chambers		25a REC'D BY REGISTRAR ST 11 ST 8E		25b REGISTRAR'S SIGNATURE APR 12 1967		25c REGISTRAR'S SIGNATURE John Charles Judge	

222



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05558

CERTIFICATE OF DEATH

05557

1 PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN Tb 3 days	c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) College Park
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Leland Memorial Hospital		d. STREET ADDRESS 4706 Tecumseh Street	
3 NAME OF DECEASED (Type or print) First Ellen Middle Ida M. Last Behrens		4 DATE OF DEATH Month April Day 28 Year 67	
5. SEX Female	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 11, 1912
9 AGE (In years last birthday) 54 yrs		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (County & State, or foreign country) Washington D. C.
12 CITIZEN OF WHAT COUNTRY U.S. A.		13 FATHER'S NAME Burton C. Millard	
14 MOTHER'S MAIDEN NAME Della Edna Wademan		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no	
16 SOCIAL SECURITY NO 212 05 0560		17 INFORMANT Walter G. Behrens Same as #2 (husband)	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma breast - metastasis to ribs, spine & pelvis DUE TO (b) Bones DUE TO (c) Bones Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1965 , 19 67 to Apr 27 , 19 67 , and that death occurred at 8 A M, from causes and on the date stated above.			
22a. SIGNATURE Walcott Etienne		22b. DATE SIGNED 4/28/67	
22c. PHYSICIAN'S NAME (Type) Walcott Etienne, M. D.		22d. ADDRESS 4715 Berwyn Rd. College Park, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/1/67	23c. NAME OF CEMETERY OR CREMATORY George Washington	23d. LOCATION (City or Town) (County) (State) Hyattsville P. G. Md.
24 FUNERAL DIRECTOR Francis Gasch's Sons		25a. REC'D BY REGISTRAR MAY 2 1967	
ADDRESS Hyattsville, Md.		25b. REGISTRAR'S SIGNATURE William Judge	

FOR STATE
HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #7 Film #G387 L/18/67 pc

05559

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05558

1 PLACE OF DEATH a COUNTY Prince George's MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution residence before admission) a STATE Maryland b COUNTY Prince George's			
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Cheverly		c LENGTH OF STAY IN 1b DOA		c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Deanwood Park			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George General Hospital				d STREET ADDRESS 1325 Eastern Avenue		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Luella				4 DATE OF DEATH Month 3 Day 30 Year 1967			
5 SEX Female		6 COLOR OR RACE White		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH 6 Oct. 1910	
9 AGE (in years last birthday) 56 yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) Virginia	
12 CITIZEN OF WHAT COUNTRY? USA.							
13 FATHER'S NAME Marion Belford				14 MOTHER'S MAIDEN NAME Alvernie Whitlock			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO		17 INFORMANT Address Mamie Sargent, Bunker Hill, W. Va			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH minutes unknown
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)					
20c TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe, M.D.				22. DATE SIGNED 4-1-67			
EXAMINER'S NAME (Type) John Kehoe, M.D.				Address (Street, city, town, or county) Riverdale, Md.			
23a BURIAL CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 4-9-67		23c NAME OF CEMETERY OR CREMATORY Fairview Cemetery		23d LOCATION (City or town) (County) (State) Gore, Frederick, Virginia	
24 FUNERAL DIRECTOR John P. Clark				ADDRESS Hagerstown, Md		25a RECD BY REGISTRAR APR 14 1967	
				25b REGISTRAR'S SIGNATURE Charles Judge			

FOR STATE
HEALTH DEPT.

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VR A15ME (5)
6M 1/67

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05560

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

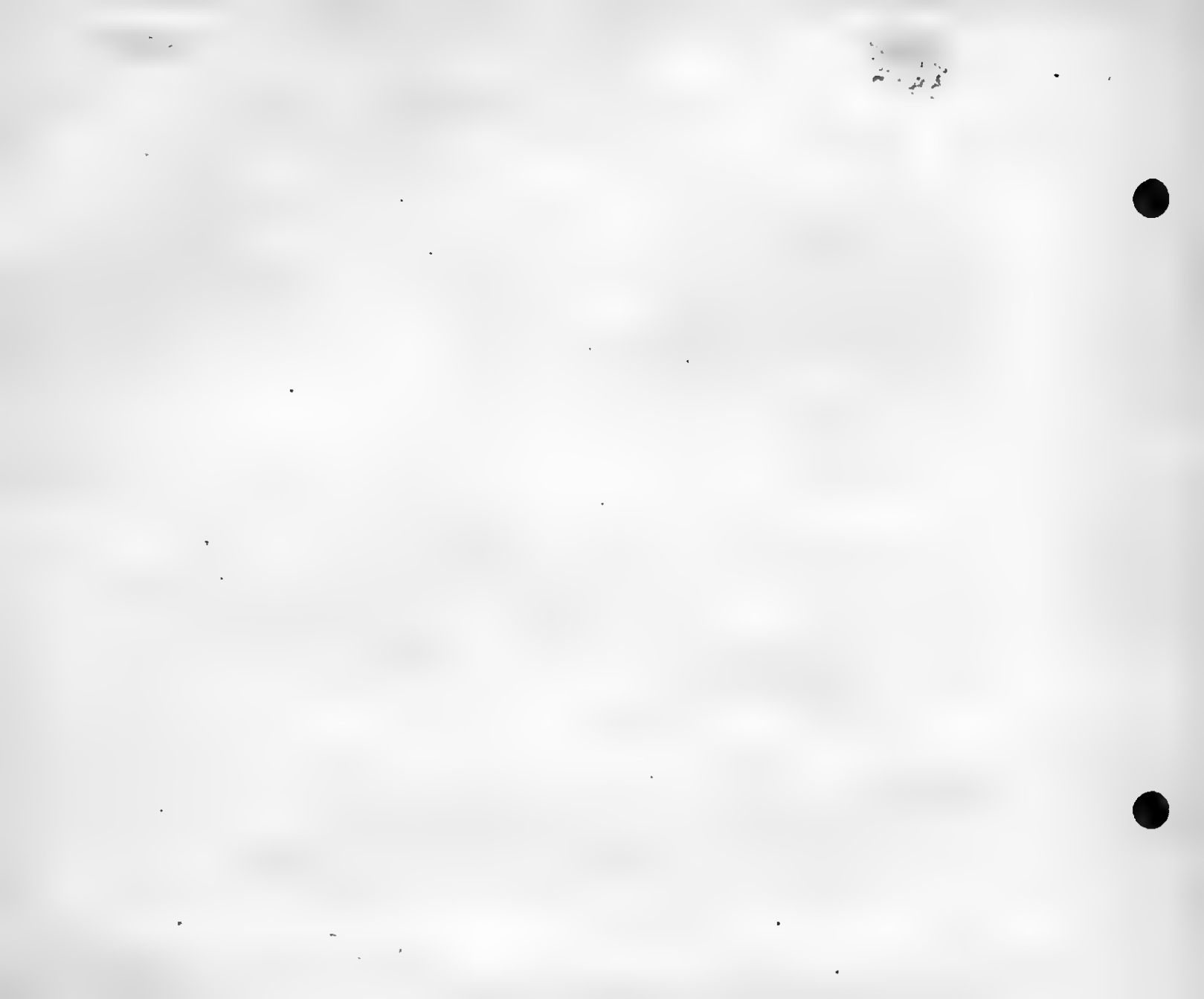
05559

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY in b. DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		d. STREET ADDRESS Short Cut Rd. Rt. 301	
3 NAME OF DECEASED (Type or print) Burtis		4 DATE OF DEATH Month 4 Day 14 Year 1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 30 Jan. 1916
9 AGE (In years to birthday) 51 yrs		10 IF UNDER 1 YEAR Months 11 Days 14 Hours 19 Min 57	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MANAGER		10b KIND OF BUSINESS OR INDUSTRY GAS STATION	
11 BIRTHPLACE (State or foreign country) WEST VIRGINIA		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME THOMAS BEVERLIN		14 MOTHER'S MAIDEN NAME VICTORIA BONNELL	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes WWII		16 SOCIAL SECURITY NO. 1014 Strauss Ave. Indian Head, Md.	
17 INFORMANT Peggy Adams		18 ADDRESS 1014 Strauss Ave. Indian Head, Md.	
18 CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intoxication (carbon monoxide) DUE TO And asphyxiation (b) From inhalation of smoke. DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 9160			
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Inhaled smoke while asleep during fire in house trailer.	
20c TIME OF INJURY Month, Day, Year Hour a.m. 4:10am pm 4-14- 1967		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f (City or town) (County) (State) Same as #2	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , inspection <input checked="" type="checkbox"/> , inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street city town or county) 4-14-67	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		22 DATE SIGNED	
23a BURIAL CREMATION, REMOVAL (Specify)		23b DATE THEREOF Burial 4-18-67	
23c NAME OF CEMETERY OR CREMATORY Pisgah Methodist Cem.		23d LOCATION (City or town) (County) (State) Pisgah Chas. Md.	
24 FUNERAL DIRECTOR The Hunt Funeral Home, Baldorf, Md.		25 REL BY REGISTRAR APR 20 1967	
26 REGISTRAR'S SIGNATURE Charles J. J...		27 REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <div> <div>1</div> <div>05561</div> </div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>CERTIFICATE OF DEATH</div> </div> <div> <div>05560</div> </div> </div>									
1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CAMP SPRINGS			c. LENGTH OF STAY IN 1b 63 YRS		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CAMP SPRINGS				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 6425 ALLEN TOWN ROAD					d. STREET ADDRESS 6425 ALLENTOWN RD.			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ELIZABETH Middle LOUISE Last BIGGS					4. DATE OF DEATH Month APRIL Day 9 Year 1967				
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 12, 1886		9. AGE (in years last birthday) 80 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10b. KIND OF BUSINESS OR INDUSTRY FARM		11. BIRTHPLACE (County & State, or foreign country) WASH. D.C.			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HENRY SROUTH					14. MOTHER'S MAIDEN NAME Elizabeth				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT JULIA E. DORE			Address SAME AS # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest DUE TO Cerebrovascular accident Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 36 hrs DUE TO Arteriosclerotic Cardiovascular Disease (c) 20 yrs									INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOT BY MEDICAL EXAMINER) None					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None				
20c. TIME OF INJURY Month, Day, Year Hour None a.m. None p.m.			20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None		20f. (City or town) (County) (State) None		
21. I certify that (I) (this hospital) attended the deceased from Sept. 19, 1962 to Present , that (I) (we) last saw the deceased alive on APRIL 7, 1967 , and that death occurred at 8:45 PM , from the causes and on the date stated above.									
22a. SIGNATURE Arthur Shaver Jr.					22b. DATE SIGNED April 9, 1967		22c. PHYSICIAN'S NAME (Type) ARTHUR SHAVER JR.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Apr. 12-1967		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery			23d. LOCATION (City, town or county) (State) Suitland, Md.	
24. FUNERAL DIRECTOR Simmons Bros.					ADDRESS Simmons Bros. 1661-Good Hope Rd., SE Wash DC		25a. REC'D BY REGISTRAR ARR 11 1967		25b. REGISTRAR'S SIGNATURE Charles Judge

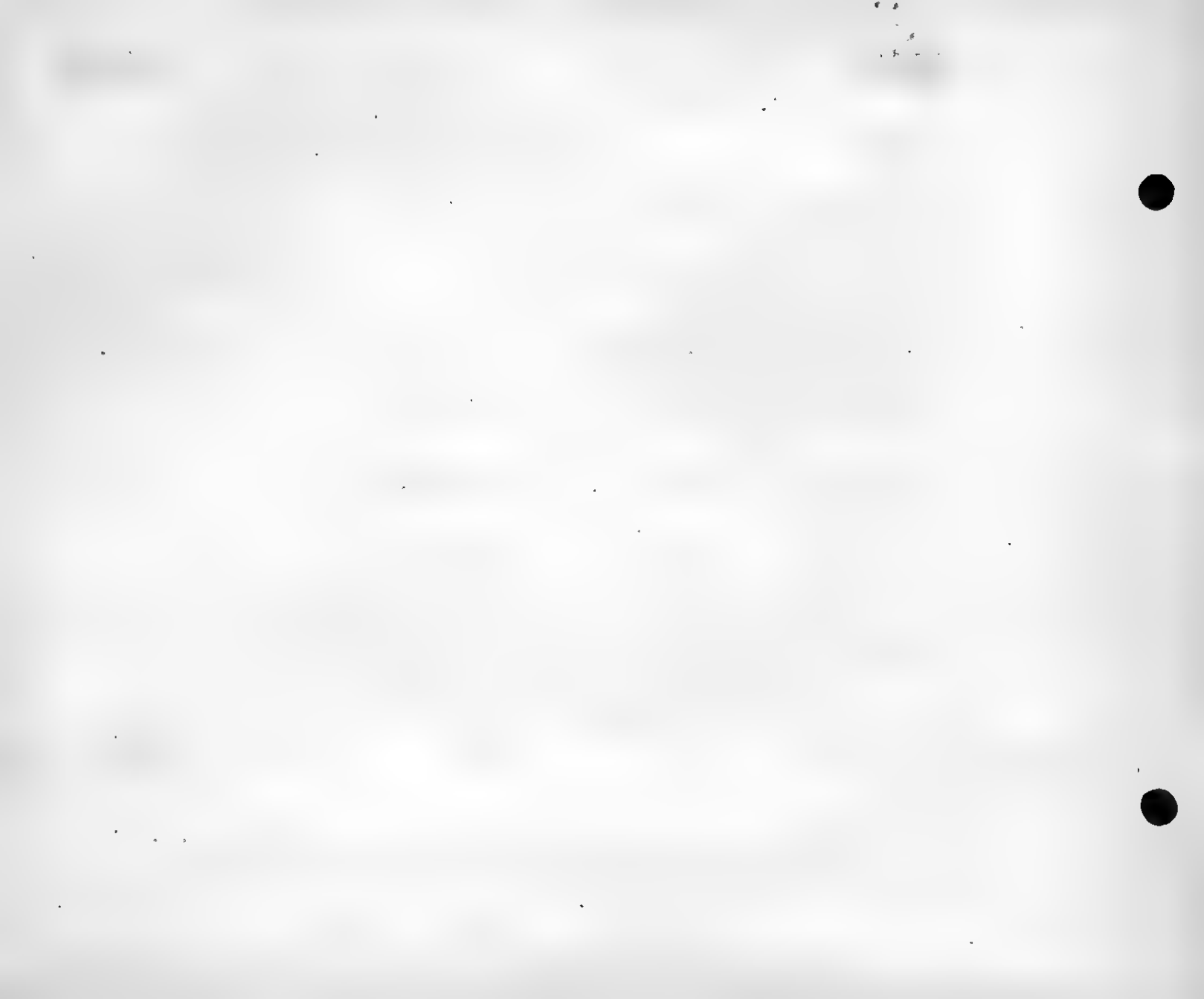


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it is to be filed in the funeral director's office. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ANDREWS c. LENGTH OF STAY IN b 26 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) USAF HOSPITAL ANDREWS						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE D.C. b. COUNTY BOLLING AIR FORCE BASE c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BOLLING AIR FORCE BASE d. STREET ADDRESS QTRS 65 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First PERCY Middle P Last BISHOP						4. DATE OF DEATH Month 8 Day APRIL Year 19 67					
5. SEX MALE		6. COLOR OR RACE CAU		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 27 MAY 1877		9. AGE (in years last birthday) 89 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OFFICER				10b. KIND OF BUSINESS OR INDUSTRY U.S. ARMY		11. BIRTHPLACE (County & State, or foreign country) TENNESSEE (CONTY UNK)		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME JOHN McELROY BISHOP						14. MOTHER'S MAIDEN NAME MARGARET WOOD					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes give war or dates of service) RET 1941				16. SOCIAL SECURITY NO. 004-46-08-44		17. INFORMANT Address GEN DONNELLY Son in law, same as #2					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCT 493 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) PNEUMONIA (c) CHRONIC DIABILITATION										INTERVAL BETWEEN ONSET AND DEATH 1 week 3 Weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (X) (this hospital) attended the deceased from 13 MAR , 19 67 , to 8 APR , 19 67 , that (I) (we) last saw the deceased alive on 8 APRIL , 19 67 , and that death occurred at 1145 P.M. , from the causes and on the date stated above.											
22a. SIGNATURE [Signature]						M.O. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED [Signature]			
22c. PHYSICIAN'S NAME (Type) RUBEN ALTMAN, CAPT, USAF, MC						22d. ADDRESS WASH, D.C. 20331 USAF HOSPITAL ANDREWS, ANDREWS AFB					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)					
BURIAL		4/13/67		ARLINGTON NATL.		ARLINGTON VA					
24. FUNERAL DIRECTOR W.W. CHAMBERS CO INC WASH. DC						25a. REC'D BY REGISTRAR DA APR 12 1967		25b. REGISTRAR'S SIGNATURE [Signature]			

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05563

CERTIFICATE OF DEATH

05562

1 PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MD b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. LENGTH OF STAY IN 1b 1 mo.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital		d. STREET ADDRESS 1435 Shepherd St., N.W.	
3 NAME OF DECEASED (Type or print) Cora L. Blalock		4. DATE OF DEATH Month 4 Day 12 Year 1967	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/12/1878
9 AGE (In years last birthday) yrs 88		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired	
11 BIRTHPLACE (County & State, or foreign country) Miss.		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Albert Gardner		14. MOTHER'S MAIDEN NAME Sarah ? Gardner	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO. 428-03-4345	
17 INFORMANT Decedent		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary tuberculosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH 1 month	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus; generalized arteriosclerosis; old cerebrovascular accident.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (X) (this hospital) attended the deceased from 3/10/1967 to 4/12/1967 , that (X) (we) last saw the deceased alive on 4/12/1967 , and that death occurred at 7:30PM , from causes and on the date stated above.			
22a. SIGNATURE Moe Weiss, M. D.		22b. DATE SIGNED 4/12/67	
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M. D.		22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 4-17-1967	23c. NAME OF CEMETERY OR CREMATORY LINCOLN	23d. LOCATION (City or Town) (County) (State) SUITLAND MARYLAND
24. FUNERAL DIRECTOR W. ERNEST HARVIS CO.		25a. REC'D BY REGISTRAR APR 17 1967	
25b. REGISTRAR'S SIGNATURE John J. Judge			

05564

CERTIFICATE OF DEATH

05563

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General Hospital</u>		e. STREET ADDRESS <u>309 Lexington Drive</u>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Gardiner</u> Last <u>Blanche</u>		4. DATE OF DEATH Month <u>April</u> Day <u>29</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 27, 1907</u>
9. AGE (in years last birthday) yrs <u>59</u>		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stonemason</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Geo. Fuller Co.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Scotland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Blanche</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Neilson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>214-03-8576</u>	
17. INFORMANT <u>Helen Blanche</u>		Address <u>309 Lexington Drive</u> <u>Silver Spring, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cornary Occlusion (Stroke)</u> DUE TO " " " Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>"</u> DUE TO (c) <u>"</u>		INTERVAL BETWEEN DEATH AND DEATH <u>4/24/67</u> <u>12/9/65</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4/9/1967</u> , 19 <u>65</u> , to <u>4/29/1967</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>4/9/1967</u> , and that death occurred at <u>12:00 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Howard I. Morse</u> M.D.		22b. DATE SIGNED <u>4/29/67</u>	
22c. PHYSICIAN'S NAME <u>Howard I. Morse M.D.</u>		22d. ADDRESS <u>7030 Carroll Ave Takoma Park Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 2, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Co., Md.</u>	
24. FUNERAL DIRECTOR <u>John B. Thomas</u> <u>Warner E. Humphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>8434 Georgia Avenue</u> <u>Silver Spring, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the top papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

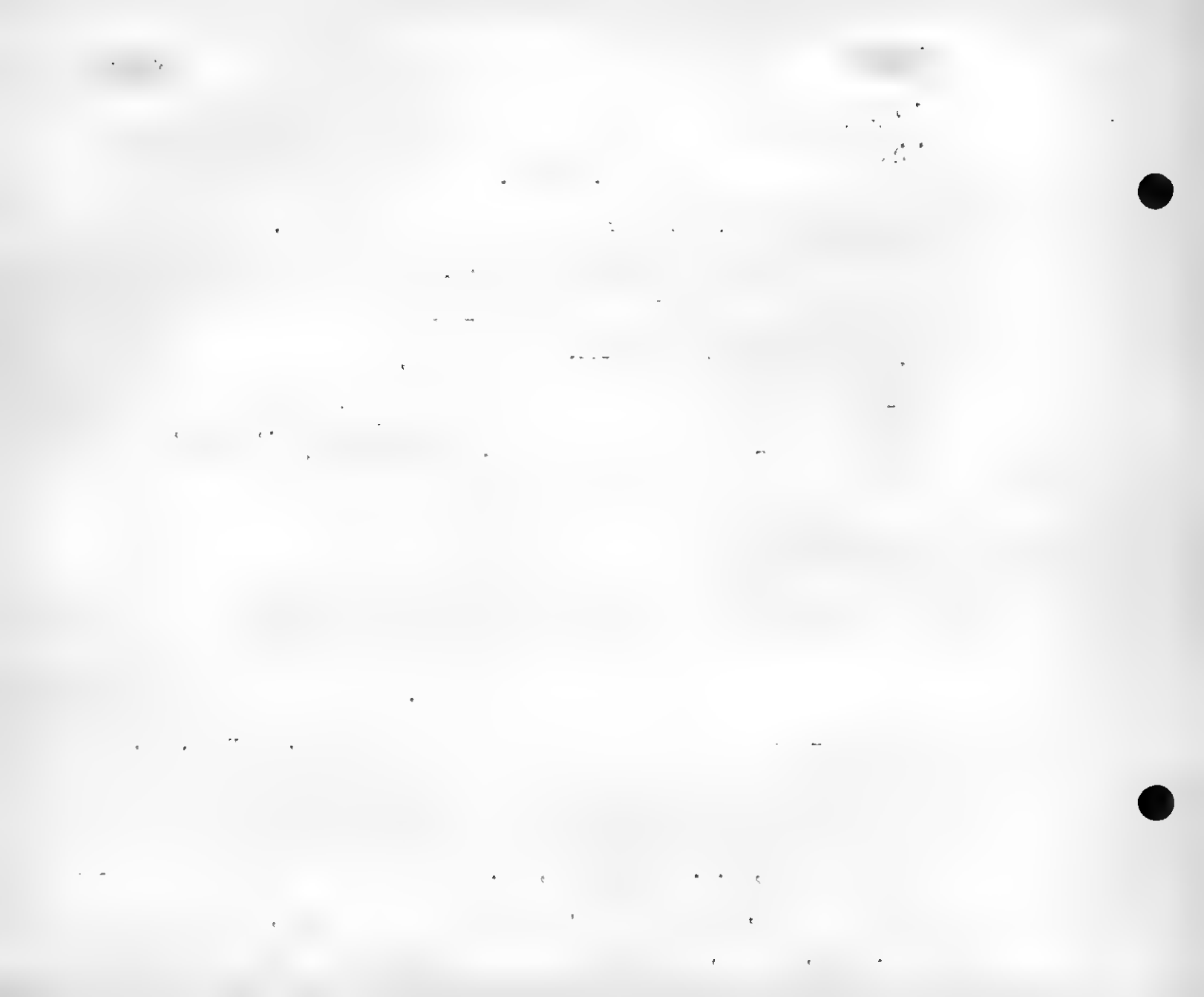
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05566

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05565

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b 1 hr. 13 min.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel 16-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital				d. STREET ADDRESS 939 Parkhill Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last Robert Francis Blankenship				4 DATE OF DEATH Month Day Year 4 30 19 67			
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 12-12-1943		9. AGE (In years last birthday) 23 yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Alum. Siding Installer Home Improvement			10b. KIND OF BUSINESS OR INDUSTRY Laurel, Maryland		11 BIRTHPLACE (State or foreign country) USA		12 CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME FRANCIS BLANKENSHIP				14. MOTHER'S MAIDEN NAME LAURA C. RIDER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO 219-40-1681		17. INFORMATION 2001 Washington St., Savage, Maryland Mrs. Linda McClure, - Sister			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Gun shot wound of abdomen DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19 WAS A TOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Shot during altercation.				
20c. TIME OF INJURY Month, Day, Year Hour am 8:44pm 4-30- 19 67		20d. INJURY OCCURRED Where <input type="checkbox"/> Not Where <input checked="" type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) 330 Prince George St., Laurel, Md.		20f. (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspect on <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input checked="" type="checkbox"/> . Undetermined manner <input type="checkbox"/>							22. DATE SIGNED 5-1-67
ACTUAL SIGNATURE John Kehoe		EXAMINER'S NAME Type) John Kehoe, M.D. Riverdale, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)			
23a. BURIAL INFORMATION BURIAL		23b. DATE THEREOF May 4, 1967		23c. NAME OF CEMETERY OR CREMATORY Ivy Hill Cemetery		23d. LOCATION (City or town) (County) (State) Laurel, Maryland	
24 FUNERAL DIRECTOR Harold S. Wade, Laurel, Maryland				25a. REC'D BY REGISTRAR DATE MAY 4 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05567 CERTIFICATE OF DEATH 05566

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE NORTH CAROLINA COUNTY BERTIE	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SEAT Pleasant		c. LENGTH OF STAY IN 1b 12 YRS.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 7203 BOOKER DRIVE		d. STREET ADDRESS WILLIAMSTON	
3. NAME OF DECEASED (Type or print) First ANNIE Middle MAE Last BOND		4. DATE OF DEATH Month APRIL Day 25 Year 1967	
5. SEX F	6. COLOR OR RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-8-1878
9. AGE (In years last birthday) 89 yrs.		IF UNDER 1 YEAR: Months 8 Days 25 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) WINDSOR NORTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME CULLEN SPELLER		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U.S. ARMY FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 577-18-728	
17. INFORMANT MARGARET MOUNTAIN Address 7203 BOOKER DR. SEAT Pleasant		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INANITION DUE TO CONGESTIVE HEART FAILURE CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. (b) 3 WEEKS DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CHRONIC GASTRITIS		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1-11, 1964 to 4-25, 1967 , that (I) (we) last saw the deceased alive on 4-25, 1967 , and that death occurred at 5:20 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Phyllis W. Cadman		22b. DATE SIGNED 4-26-67	
22c. PHYSICIAN'S NAME (Type) M.D.		22d. ADDRESS 7220 BOOKER DR SEAT Pleasant	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 4-29-67	23c. NAME OF CEMETERY OR CREMATORY COLEMAN	23d. LOCATION (City, town or county) (State) GUM SPRINGS, VA.
24. FUNERAL DIRECTOR ROLLINS FUN. HOME INC.		25a. REC'D BY REGISTRAR 4339 HUNT PL. NE	
25b. REGISTRAR'S SIGNATURE MAV 1 1967		25c. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03568

CERTIFICATE OF DEATH

03567

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 10 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS 3708 35th Street	
3. NAME OF DECEASED (Type or print) First Henrietta Middle E Last Bond		4. DATE OF DEATH Month April Day 26 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 16 Oct., 1891
9. AGE (In years last birthday) 75 yrs		10. IF UNDER 1 YEAR Months 75 Days 75 Hours 75 Min. 75	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk- Peoples Drug Store		10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Maryland	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Oliver L. Bond		14. MOTHER'S MAIDEN NAME Minnie Lerp	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO Miss Ruth Olive Bond same as above	
17. INFORMANT Miss Ruth Olive Bond same as above		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Failure 5810 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Cirrhosis of the Liver DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (was not present) attended the deceased from April 17, 1967 to April 26, 1967 , that (I) (was not present) saw the deceased alive on April 26, 1967 , and that death occurred on April 26, 1967 from causes and on the date stated above.			
22a. SIGNATURE Benjamin S. Miller		22b. DATE SIGNED 4-27-67	
22c. PHYSICIAN'S NAME (Type) Benjamin S. Miller, M. D.		22d. ADDRESS 3824 - 34th St., Mr. Rainier, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 1, 1967	
23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery Prince Georges Co. Md.		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR Charles H. Miller Co. Wash. D.C.		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE MAY 1 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05569

CERTIFICATE OF DEATH

05568

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEO.</u> <u>3704 - 40th Pl.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>COTTAGE CITY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>COTTAGE CITY</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3704 - 40th PLACE</u>				d. STREET ADDRESS <u>3704 - 40th PLACE</u>			
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>MINOR</u> Last <u>BOTTS</u>				4. DATE OF DEATH Month <u>APRIL</u> Day <u>10</u> Year <u>1967</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT. 14, 1876</u>	9. AGE (In years last birthday) <u>90</u> yrs.	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BUSINESS AGENT</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>STEAM FITTERS UNION</u>		11. BIRTHPLACE (County & State, or Foreign country) <u>VIRGINIA</u>	
13. FATHER'S NAME <u>THOMAS BOTTS</u>				14. MOTHER'S MAIDEN NAME <u>SOPHIA HASLIP</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>				16. SOCIAL SECURITY NO. <u>578 036148</u>		17. INFORMANT <u>ELLSWORTH N. BOTTS</u> Address <u>6628 23 PL LEWISDALE, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO (b) <u>Arteriosclerosis, arteriosclerotic heart disease</u> DUE TO (c) <u>disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5/1</u> , 19 <u>52</u> , to <u>4/10</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4/10</u> , 19 <u>67</u> , and that death occurred at <u>6 P.</u> M., from the causes and on the date stated above.							
22a. SIGNATURE <u>Earl W. Graeff</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4-10-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>EARL W. GRAEFF, M.D.</u>				22d. ADDRESS <u>2716 Kirkwood Pl., W. Hyattsville, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4-14-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN</u>		23d. LOCATION (City, town or county) (State) <u>BLADENSBURG, MARYLAND</u>	
24. FUNERAL DIRECTOR <u>W.W. CHAMBERS CO - RIVERDALE, MD.</u>				25a. REC'D BY REGISTRAR DATE <u>APR 12 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #13 infor, taken from birth cert.

05570

CERTIFICATE OF DEATH

05569

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Res dence before admiss on) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 3 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS RFD # 3914	
3. NAME OF DECEASED (Type or print) First Baby Middle Boy Last Bowman		4. DATE OF DEATH Month April Day 15 Year 1967	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 12, 1967
9. AGE (In years last birthday) yrs 3		10. IF UNDER 1 YEAR Months 3 Days 3 Hours 3 Min 3	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Prince George's, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ellis Stanley Bowman		14. MOTHER'S MAIDEN NAME Agnes Anita Griffith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ant. type congenital abnormalities DUE TO (b) Hydrocephalus, Cleft palate, Cardiac murmur, DUE TO (c) Imperforate anus			INTERVA. BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from April 12, 1967 , to April 15, 1967 , that (I) (we) saw the deceased alive on April 15, 1967 , and that death occurred at 3:15 AM from causes and on the date stated above.			
22a. SIGNATURE <i>A. Clark Holmes</i>		22b. DATE SIGNED 4/17/67	
22c. PHYSICIAN'S NAME (Type) A. Clark Holmes, M.D.		22d. ADDRESS 4108 Pratt St., Upper Marlboro, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE THEREOF 4/22/67	23c. NAME OF CEMETERY OR CREMATORY Prince George's Gen. Hosp	23d. LOCATION (City or Town) (County) (State) Cheverly PG Maryland
24. FUNERAL DIRECTOR Harry W. Penn, Jr., Admin., Cheverly, Md.		25a. REC'D BY REGISTRAR APR 25 1967	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05571

CERTIFICATE OF DEATH

05570

1 PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN Tb 1 day d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant d. STREET ADDRESS 6906 B Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Robert Middle D. Last Boyer		4 DATE OF DEATH Month April Day 7 Year 1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 11/11/11
9 AGE (In years last birthday) 55 yrs.		10 IF UNDER 1 YEAR Months 0 Days 0 IF UNDER 24 HRS. Hours 0 Min 0	
10a USAL OCCUPATION (Give kind of work done during most of working life, even if retired) STEAMFITER		10b KIND OF BUSINESS OR INDUSTRY Construction	
11 BIRTHPLACE (County & State, or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John E. Boyer		14. MOTHER'S MAIDEN NAME Pamela Dunlap	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT Donald D. Boyer		Address Maryland 3400 Brinkley Rd. Oxon Hill	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 4/10/1 DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1957 , 19 4/7 , that (I) (we) last saw the deceased alive on 4/6 , 19 67 , and that death occurred at 7:25 A M, from causes and on the date stated above.			
22a. SIGNATURE Peter Duus		22b. DATE SIGNED 4/7/67	
22c. PHYSICIAN'S NAME (Type) Dr. Peter Duus		22d. ADDRESS 6124 Central Ave., Capitol Hgts. Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b DATE THEREOF 4/10/67	23c NAME OF CEMETERY OR CREMATORY Edge Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Charles Town, West Virginia
24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home 4308 Suitland Road, Suitland, Maryland		25c. REC'D BY REGISTRAR APR 11 1967 DATE	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reattach the pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
SM 1/63

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05572

05571

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>WASH. DC.</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CHRYSLER</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WASH. D.C.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PRINCE GEORGES GEN. HOSP.</u>				d. STREET ADDRESS <u>2824 DEVONSHIRE PL. NW</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>GEORGE VINCENT BRENNEMAN</u>				4. DATE OF DEATH Month Day Year <u>APRIL 5, 1967</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>JULY 4, 1893</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALESMAN</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>REAL ESTATE & INSURANCE</u>		11. BIRTHPLACE (State or foreign country) <u>PENNA.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>ELI BRENNEMAN</u>				14. MOTHER'S MAIDEN NAME <u>MATILDA MARKLE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>578-28-7093</u>		17. INFORMANT Address <u>RENSHAWTON RD 4014 SUMMIT DR</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Wounds Multiple Stab</u> DUE TO (b) <u>Severe Fracture Chest.</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <u>Skull Crushing Injury Abdomen & Chest</u> DUE TO (c) <u>Skull Crushing Injury Abdomen & Chest</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Acclosure of Jugular Vein Blood of L</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <u>auto accident</u>							
20c. TIME OF INJURY Hour <u>6:30</u> p.m. <u>April 5, 1967</u>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Roadway on Oldville Rd</u>		20f. (City or town) (County) (State) <u>Pr Geo Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Dayton Watkins</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>DAYTON O WATKINS</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>4/8/1967</u>		22c. NAME OF CEMETERY OR CREMATORY <u>George Washington</u>	
23. FUNERAL DIRECTOR <u>W. W. Chambers, Inc.</u>				ADDRESS <u>5127 Spring</u>		24a. REC'D BY REGISTRAR <u>APR 11 1967</u>	
				24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>4-7-67</u>	

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1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05573

05572

1. PLACE OF DEATH a COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if instit. on Residence before admission) a STATE Maryland b COUNTY Prince George	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c LENGTH OF STAY IN IS 3 days	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		d STREET ADDRESS 4315 Oglethorpe Street	
3. NAME OF DECEASED (Type or print) First Mary Middle H. Last Brewer		4. DATE OF DEATH Month April Day 1 Year 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 1, 1875
9. AGE (In years, days, months, and years) 92		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Retired Editorial Dept		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government	
11. BIRTHPLACE (County & State, or foreign country) Alabama		12. CITIZEN OF WHAT COUNTRY? U.S. A.	
13. FATHER'S NAME Samuel Blount Brewer		14. MOTHER'S MAIDEN NAME Marian MacFarlane	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 678 60 5195	
17. INFORMANT Miss Virginia W. Brewer (niece)		Address Same as #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarct DUE TO 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO 4-161 (c)		INTERVAL BETWEEN ONSET AND DEATH 3-29-67 4-1-67	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Dec 15, 1966 , to April 1, 1967 , that (I) (we) last saw the deceased alive on 11-1-66 , and that death occurred at 3:10 P.M. from causes and on the date stated above			
22a. SIGNATURE Aaron Deitz		22b. DATE SIGNED 4-26-67	
22c. PHYSICIAN'S NAME (Type) Aaron Deitz		22d. ADDRESS Prince George Plaza Hyattsville, Md.	
23a. BURIAL, CREMATION, or other disposal (Specify) BURIAL	23b. DATE THEREOF 4/5/67	23c. NAME OF CEMETERY OR CREMATORY Hillside	23d. LOCATION (City or Town) (County) (State) Anniston Alabama
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE APR 4 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove exchange papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05574

Item 9 Filed 4/11/67

CERTIFICATE OF DEATH

05573

1 PLACE OF DEATH a COUNTY Prince Georges b CITY OR TOWN (If outside corporate limits, write RJRAL and give nearest town) Cheverly c LENGTH OF STAY IN TB 1 hr 10 mins d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b COUNTY Prince Georges c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairmont Hgts d STREET ADDRESS 709-62nd Ave. e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Edith Middle I. Last Brooks				4 DATE OF DEATH Month April Day 3 Year 19 67			
5 SEX Female		6 COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH 10/17/15	
9. AGE (In years last birthday) 52 5 yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) 52 5 yrs	
11 BIRTHPLACE (County & State, or foreign country) Washington, .DC.				12 CITIZEN OF WHAT COUNTRY USA			
13 FATHER'S NAME Eli Brooks				14 MOTHER'S MAIDEN NAME Ruth Pinkney			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO.		17 INFORMANT John Brooks-7316 73rd Ct. Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cama DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Cerebrovascular Hemorrhage DUE TO (c) Arteriosclerosis.						INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 3, 1967 , to April 3, 1967 , that (I) (we) last saw the deceased alive on April 3, 1967 , and that death occurred at 10:15 AM , from causes and on the date stated above.							
22a. SIGNATURE Edwin J. Jensen				22b. DATE SIGNED PM		22c. PHYSICIAN'S NAME (Type) Edwin J. Jensen, M.D.	
22d. ADDRESS Prince Georges General Hospital				22e. DATE SIGNED APR 7 1967			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE THEREOF		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)	
Burial		4/7/67		Harmony Memorial Park		Maryland	
24 FUNERAL DIRECTOR Stewart Funeral Home				25a REC'D BY REGISTRAR Charles Judge			
25b REGISTRAR'S SIGNATURE Charles Judge				25c REGISTRAR'S SIGNATURE Charles Judge			

122

in Brooks-7316 73rd Ct. Maryland
Kentland,

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
05575 CERTIFICATE OF DEATH 05574									
1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Pr. Geo.</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>			c. LENGTH OF STAY IN 1b <u>1 1/2 Hours</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General Hospital</u>					d. STREET ADDRESS <u>3134 Nicholson Pl.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mrs. CLARA</u> Middle <u>L</u> Last <u>BROWN</u>					4. DATE OF DEATH Month <u>April</u> Day <u>3</u> Year <u>1967</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 24, 1886</u>		9. AGE (In years last birthday) <u>80</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>at Home</u>		11. BIRTHPLACE (County & State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Randolph A. Hawkins</u>					14. MOTHER'S MAIDEN NAME <u>Hannah Jackson</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>					16. SOCIAL SECURITY NO. <u>Andrew J. Brown - 5009 40th Pl. Hyattsville MD</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Thrombosis</u> DUE TO (c) <u>Coronary atherosclerosis</u>								INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1963</u> to <u>7-3</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4-3</u> , 19 <u>67</u> , and that death occurred at <u>8:00 P.M.</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>Donald C. Edgren</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <u>Apr. 3, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>DONALD C. EDGREN</u>					22d. ADDRESS <u>Hyattsville, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>April 6, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Annapolis, Prince Georges Md</u>		
24. FUNERAL DIRECTOR <u>Arthur Walters, 254 Carroll St NW. DC</u>					25a. REC'D BY REGISTRAR <u>APR 7 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. Jago</u>		



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05576

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05575

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN TB DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		e. STREET ADDRESS Box 55	
3 NAME OF DECEASED (Type or print) Isaac Brown		4 DATE OF DEATH 4 10 1967	
5 SEX Male	6 COLOR OR RACE Negro	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 11 Dec. 1913
9 AGE (in years last birthday) 53 yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction	
10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (Home or foreign country) M.C.	
12 CITIZEN OF WHAT COUNTRY? U.S.A.		13 FATHER'S NAME George Brown	
14 MOTHER'S MAIDEN NAME Unknown		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes W.W. 2	
16 SOCIAL SECURITY NO		17 INFORMANT William Brown Crownsville, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c)			INTERVAL BETWEEN ONSET AND DEATH minutes unknown
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> hot While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspect on <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion on death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe, M.D. M.D.		22. DATE SIGNED 4-11-67	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		Address (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF 4-14-1967	23c NAME OF CEMETERY OR CREMATORY Balto. Natl.	23d LOCATION (City or town) (County) (State) Baltimore, Md.
24 FUNERAL DIRECTOR William Beesett, Crownsville, Md.		25a REC'D BY REGISTRAR APR 13 1967	
25b REGISTRAR'S SIGNATURE John Charles Judge			

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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VR A15ME (5)
6M 1/67

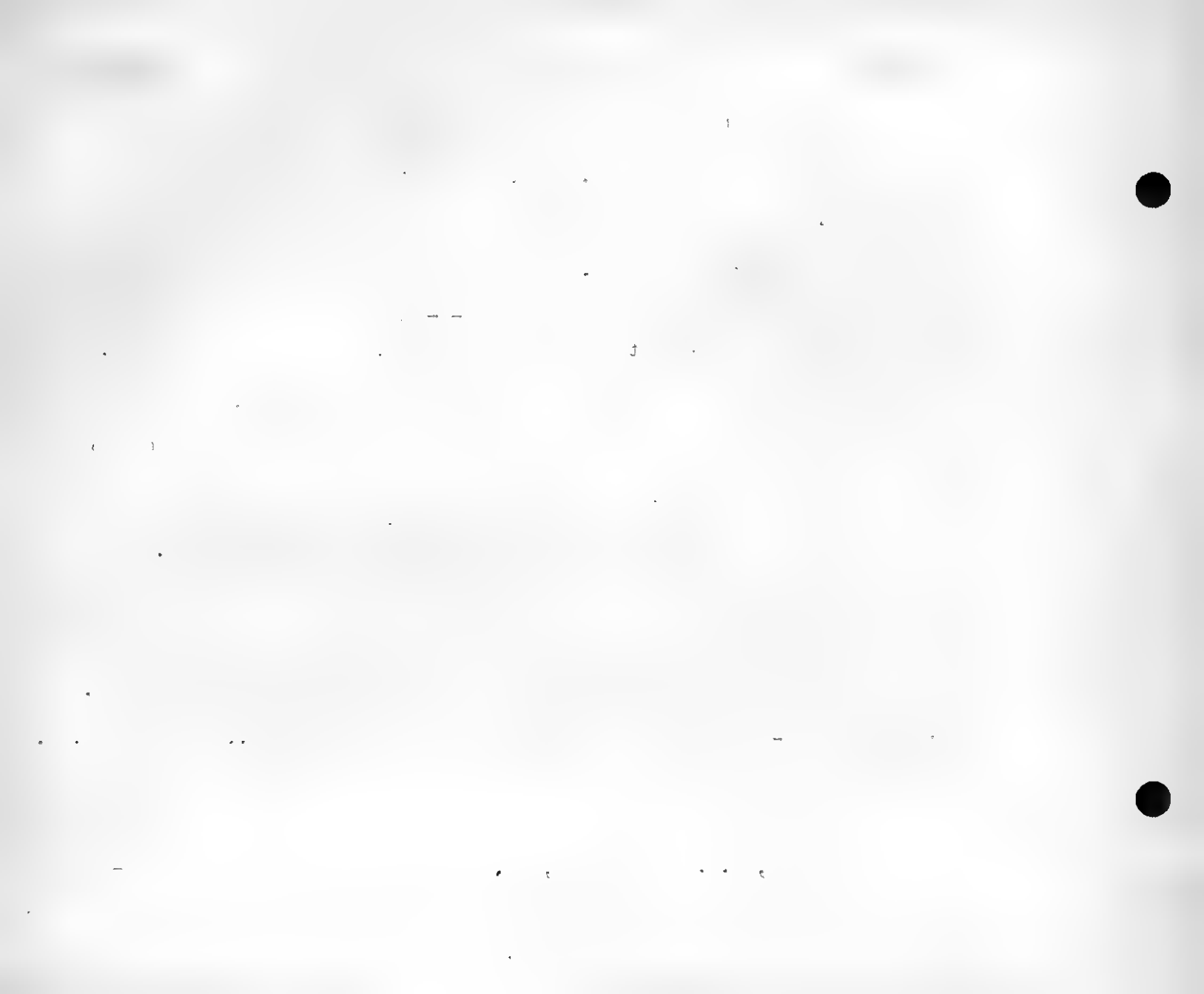
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05577

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05576

1 PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Edmonston	
c. LENGTH OF STAY IN b. 5 hrs. 20 min.		d. STREET ADDRESS 5102 Lafayette Place	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Charles K. Buler		4 DATE OF DEATH Month 4 Day 20 Year 1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 11-2-1918
9 AGE (in years last birthday) 48 yrs		10 UNDER 1 YEAR Months 19 Days 67 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during last week of life even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Conn.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward O. Buler		14. MOTHER'S MAIDEN NAME Margaret A. Shannon	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW II (If yes give year or date of service)		16. SOCIAL SECURITY NO 139 16 1644	
17. INFORMANT Rosemary Buler Same as #2 (wife)		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Laceration of brain DUE TO And Right hemothorax from multiple rib fractures (b) And right pneumothorax from laceration of lung. DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 6 hrs			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18) Driver of car which ran off road and hit guard rail.	
20c. TIME OF INJURY Month, Day, Year Hour 9:10pm 4-19-1967		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.)		20f. (City or town) (County) (State) 3800 block Kenilworth Ave., Bladensburg, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE 		22. DATE SIGNED 4-21-67	
EXAMINER'S NAME (Type) John Kehoe, M.D.		Address (Street, city, town, or county) Riverdale, Md.	
23a. BURIAL (Cremation) Burial		23b. DATE THEREOF 4/25/67	
23c. NAME OF CEMETERY OR CREMATORY Alexandria National		23d. LOCATION (City or town) (County) (State) Alexandria Va.	
24. FUNERAL DIRECTOR Francis Gasch's Sons		Address Hyattsville, Md.	
25a. REC'D BY REG. STRAR DATE APR 24 1967		25b. REG. STRAR'S SIGNATURE 	



05578

CERTIFICATE OF DEATH

05578

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bladensburg		c. LENGTH OF STAY IN 1b Bladensburg	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5440 Taylor Street		d. STREET ADDRESS 5440 Taylor Street	
3. NAME OF DECEASED (Type or print) Ethel Clair Butler		4. DATE OF DEATH Month April Day 29 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 14, 1880
9. AGE (in years) 86		10. IF UNDER 1 YEAR Months 29 Days 19	
11. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Housewife		12. KIND OF BUSINESS OR INDUSTRY Own Home	
13. BIRTHPLACE (County & State, or foreign country) West Virginia		14. CITIZEN OF WHAT COUNTRY U.S.A.	
15. FATHER'S NAME Christopher C. Sypolt		16. MOTHER'S MAIDEN NAME Unknown	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		18. SOCIAL SECURITY NO. 235 18 2675	
19. INFORMANT Mrs. Nellie V. Kline		Address Same as #2 (daughter)	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO (b) Myocardial infarction DUE TO (c) Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) generalized arteriosclerosis			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from July , 19 65 , to April 29, 1967 , that (I) (we) last saw the deceased alive on April 29, 1967 , and that death occurred at 12:30 AM , from causes and on the date stated above.			
22a. SIGNATURE Don B. Cameron M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED April 29, 1967
22c. PHYSICIAN'S NAME (Type) DON B. CAMERON		22d. ADDRESS 3503 PERRY ST. MT. RAINIER	
23a. BURIAL CREMATION, etc. Burial	23b. DATE THEREOF 5/2/67	23c. NAME OF CEMETERY OR CREMATORY Greenway	
23d. LOCATED ON (City or Town) (County) (State) Burkley Springs West Va		23e. REC'D BY REGISTRAR Charles Judge	
24. FUNERAL DIRECTOR Francis Gasch's Sons		25. REG. STRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

05579

5579

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 5 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro d. STREET ADDRESS Box 3000, Upper Marlboro, Md. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Sheldon Middle Elwood Last Cadle		4. DATE OF DEATH Month April Day 10 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/27/89
9. AGE (In years last birthday) 77 yrs		10. IF UNDER 1 YEAR Months 10 Days 19 Hours 67 Min	11. IF UNDER 24 HRS. Hours 10 Min 19
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Own Business	11. BIRTHPLACE (County & State, or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Brooke Cadle	
14. MOTHER'S MAIDEN NAME Mary Strong		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No	
16. SOCIAL SECURITY NO. ---		17. INFORMANT Horace S. Cadle - Washington, D.C.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Circulatory Collapse DUE TO (b) Diabetic Acidosis CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (a) (this hospital) attended the deceased from April 5, 1967 to April 10, 1967 , that (a) (we) last saw the deceased alive on April 10, 1967 , and that death occurred at 1:15 P.M. from causes on and on the date stated above.			
22a. SIGNATURE B. Bahrami M.D.		22b. DATE SIGNED 4/10/67	
22c. PHYSICIAN'S NAME (Type) B. Bahrami, M.D.		22d. ADDRESS 3000 Naylor Rd. S.E., D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4/13/67	23c. NAME OF CEMETERY OR CREMATORY Belair Memorial Gardens	23d. LOCATION (City or Town) (County) (State) Belair Md.
24. FUNERAL DIRECTOR Ritchie Bros. Upper Marlboro, Md.		25a. REC'D BY REGISTRAR DATE APR 12 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #3 Film #G388 3/25/67 ps

CERTIFICATE OF DEATH

05580

05580

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Magnolia Gardens Nursing Home		d. STREET ADDRESS 4104 Hamilton St.	
3. NAME OF DECEASED (Type or print) Zora First L. Middle Carincross / Cairncross		4. DATE OF DEATH Month April Day 7 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 23, 1888
9. AGE (In years last birthday) yrs. 78		10. USUAL OCCUPATION (Give kind of work done during most of last year) Housewife	
10b. KIND OF BUSINESS OR Own home		11. BIRTHPLACE (County & State, or foreign country) Balt. Co. Maryland	
12. CITIZEN OF WHAT COUNTRY U.S. A.		13. FATHER'S NAME Benjamin Franklin Frost	
14. MOTHER'S MAIDEN NAME Rosa A		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no	
16. SOCIAL SECURITY NO. 578 28 6239		17. INFORMANT Wm. W. Carincross University Park, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) arteriosclerosis generalized DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH 1 hour 1 year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1966 , 19 April 7 , 1967, that (I) (we) last saw the deceased alive on April 6 , 1967, and that death occurred at 430 M, from causes and on the date stated above.			
22a. SIGNATURE Leon Levitsky		22b. DATE SIGNED 7/2/67	
22c. PHYSICIAN'S NAME (Type) Leon Levitsky		22d. ADDRESS Mt Rainier, Md.	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF April 11, 1967	23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery	23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR APR 10 1967	
25b. REGISTRAR'S SIGNATURE Wm. W. Carincross			

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VR A15 (4)
25M 1/67

05581		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		05581	
CORRECTED COPY		CERTIFICATE OF DEATH		CORRECTED COPY	
1. PLACE OF DEATH a. COUNTY PRINCE GEORGES b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AFB c. LENGTH OF STAY IN 1b 12 Days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF HOSPITAL ANDREWS		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HILLSIDE d. STREET ADDRESS 1204 54TH AVE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) WILLIAM HOMER CARDINAL		4. DATE OF DEATH Month Day Year APRIL 28 1967			
5. SEX MALE	6. COLOR OR RACE CAU	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 1921 27 FEB 22	9. AGE (In years last birthday) 46 yrs	10. IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) USAF		10b. KIND OF BUSINESS OR INDUSTRY USAF		11. BIRTHPLACE (County & State, or foreign country) GREEN BAY, WISC 12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME CLAUDE CARDINAL		14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES MED RET MAY \$9		16. SOCIAL SECURITY NO.		17. INFORMANT WIFE Address SAME AS #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4 Infarction, posterior left and right ventricular wall and septum. DUE TO (b) Pneumococcal pneumonia, right upper lobe. DUE TO (c) Pneumococcal septicemia. (c) Severe Coronary arteriosclerosis.					INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that (he) (this hospital) attended the deceased from 16 Apr 1967, to 28 Apr 1967 that (he) (we) lost saw the deceased alive on 28 Apr 1967, and that death occurred at 5:50 AM, from causes and on the date stated above.					
22a. SIGNATURE Maxwell W. Steel Jr		M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) MAXWELL W. STEEL JR Colonel, USAF MC		22d. ADDRESS USAF HOSPITAL ANDREWS ANDREWS AFB, WASH, D.C. 20331			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 2 MAY 1967	23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL C. EMERY		23d. LOCATION (City or Town) (County) (State) ARLINGTON, VIRGINIA	
24. FUNERAL DIRECTOR ROBERT W. MILNER JR 1308 SUTLAND ROAD, BALTIMORE, MARYLAND		25a. RECD BY REGISTRAR DATE MAY 2, 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

MEDICAL CERTIFICATION

Corrected copy of the paper, 1877

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VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05582

CERTIFICATE OF DEATH

05582

1 PLACE OF DEATH a. COUNTY PRINCE GEORGES b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AFB c. LENGTH OF STAY IN IB DOA d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF HOSPITAL ANDREWS		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OXON HILL d. STREET ADDRESS 7606 BOCK ROAD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last ANNA JOSEPHINE CASTER		4 DATE OF DEATH Month Day Year APRIL 26 19 67	
5 SEX FEMALE	6 COLOR OR RACE CAU	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 10 Apr 1897
9 AGE (In years last birthday) 70		10 IF UNDER 1 YEAR Months Days Hours Min 24 00 00 00	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		11b. KIND OF BUSINESS OR INDUSTRY NA	
11. BIRTHPLACE (County & State, or foreign country) SWEDEN		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN OSTERLUND		14. MOTHER'S MAIDEN NAME MAHTILDA JOHNSON	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO NA		16 SOCIAL SECURITY NO 038-12-4662	
17 INFORMANT DAUGHTER		Address SAME AS #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ATHEROSCLEROSIS CORONARY ARTERIES -4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (X) (this hospital) attended the deceased from 8 April, 19 67 to 24 April 1967 , that (X) (we) lost saw the deceased alive on 24 April 1967 , and that death occurred at 2:25 PM , from causes and on the date stated above.			
22a. SIGNATURE Maxwell W. Steel, Jr.		22b. DATE SIGNED 27 April 67	
22c. PHYSICIAN'S NAME (Type) MAXWELL W. STEEL, JR. COLONEL, USAF MC		22d. ADDRESS USAF Hospital Andrews Andrews AFB, Wash DC 20331	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 5/1/67	23c. NAME OF CEMETERY OR CREMATORY PAWTUCKET	23d. LOCATION (City or Town) (County) (State) WARWICK, R.I.
24 FUNERAL DIRECTOR W.W. CHAMBERS CO. INC. WASH. D.C.		25a. REC'D BY REGISTRAR DATE MAY 1 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05583

CERTIFICATE OF DEATH

05583

1. PLACE OF DEATH a. COUNTY <u>PR Geo</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>same as # 1 A</u> b. COUNTY <u>same as # 1 B</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville, Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>same as # 1 B</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in the hospital, give street address) <u>5918 Gallatin St</u>		d. STREET ADDRESS <u>same as # 1 D</u>	
3. NAME OF DECEASED (Type or print) <u>MAGGIE IRENE CAUDILL</u>		4. DATE OF DEATH <u>APR 28 1967</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 17, 1895</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (County & State, or foreign country) <u>ASH Co. N. Carol</u>
13. FATHER'S NAME <u>Byron Sturgell</u>		14. MOTHER'S MAIDEN NAME <u>Martha Pennington</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>	
17. INFORMANT <u>MRS GLADYS GREER</u>		Address <u>same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Failure</u> DUE TO (b) <u>Hypertensive/arteriosclerotic</u> DUE TO (c) <u>Cardio Vascular Disease & Hemiplegia 15yr.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 hr +</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>No</u>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1957</u> , 19 <u>67</u> to <u>APR 27</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>APR 27</u> , 19 <u>67</u> , and that death occurred at <u>3:30 A</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>4-28-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>4713 Berwyn Rd</u>		22d. ADDRESS <u>Calleye Park, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4/30/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ashlawn</u>	23d. LOCATION (City or town) (County) (State) <u>Jefferson n.c.</u>
24. FUNERAL DIRECTOR <u>Francis Hensch's Sons Hyattsville, Md.</u>		25a. REC'D BY REGISTRAR <u>[Signature]</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	
DATE <u>MAY 2 1967</u>			

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05584

CERTIFICATE OF DEATH

05584

1 PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN Tb 2 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. STREET ADDRESS 12613 Craft Lane	
3. NAME OF DECEASED (Type or print) First Albert Middle (NMN) Last Celich Sr.		4. DATE OF DEATH Month April Day 26 Year 19 67	
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 22 Dec., 1916
9 AGE (In years last birthday) yrs 50		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Anylist		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy	
11 BIRTHPLACE (County & State, or foreign country) Wisconsin		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Iso Celich		14. MOTHER'S MAIDEN NAME Eva Hidech	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO. 389-10-1553	
17 INFORMANT Mrs. Dorothy K. Celich, Same as #2		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Cardiac failure DUE TO (c) Coronary artery disease		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 11. 2-2-1967 (Heart)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1/27/67 , 19 67 , to 2/26/67 , 19 67 , that (I) (we) last saw the deceased alive on 19-1 , and that death occurred at 6:25 PM , from causes on and on the date stated above.			
22a. SIGNATURE Albert Roth, M. D.		22b. DATE SIGNED 2/26/67	
22c. PHYSICIAN'S NAME (Type) Albert Roth, M. D.		22d. ADDRESS 5409 Riverdale Rd. Riverdale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Apr. 29, 1967	
23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION (City or Town) (County) (State) Wheaton, Maryland	
24. FUNERAL DIRECTOR W.W. Chambers Co. ADDRESS Riverdale, Md.		25. REC'D BY REGISTRAR MAY 1 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05585

CERTIFICATE OF DEATH

05585

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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M

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Carroll Manor</u>				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>-----</u> b. COUNTY <u>-----</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u> d. STREET ADDRESS <u>1504 23rd. St., SE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary Veronica Chappellear</u>				4. DATE OF DEATH Month Day Year <u>April 17 1967</u>									
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/15/1886</u>		9. AGE (In years last birthday) yrs <u>80</u>		10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Examiner-Bureau of Engraving</u>				10b. KIND OF BUSINESS OR INDUSTRY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Charles Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Thomas J. Chappellear</u>				14. MOTHER'S MAIDEN NAME <u>Ellen Rose Morris</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO <u>Hospital Records</u>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> DUE TO <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <u>7 days 1 year</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Interstitial Pneumonia</u>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (the hospital) attended the deceased from <u>Oct. 7</u>, 19<u>58</u>, to <u>April 17</u>, 19<u>67</u>, that (I) we last saw the deceased alive on <u>April 17</u>, 19<u>67</u>, and that death occurred at <u>11:30</u> p.m., from causes and on the date stated above.													
22a. SIGNATURE <u>Thomas F Collins</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>p.m.</u>					
22c. PHYSICIAN'S NAME (Type) <u>Thomas F Collins, M.D.</u>						22d. ADDRESS <u>322 H St. N.E. Washington, D.C.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>4/20/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>				23d. LOCATION (City or Town) (County) (State) <u>Suitland, Maryland</u>			
24. FUNERAL DIRECTOR <u>Jas. T. Ryan, Inc.</u>						25a. REC'D BY REGISTRAR <u>APR 20 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

05586

CERTIFICATE OF DEATH

05586

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN lb 30 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenbelt d. STREET ADDRESS 20 E. Hillside Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Faith M. Charland		4. DATE OF DEATH Month Day Year April 11 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 25, 1902
9. AGE (In years last birthday) 64 yrs		10. IF UNDER 1 YEAR Months Days Hours Min 30 Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (County & State, or foreign country) Michigan		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Fred Polkey		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 386-03-5156	
17. INFORMANT Mr. Neil F. Charland - (Son)		Address 8324 -Verona Carrollton,	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Failure DUE TO (b) Cirrhosis of the Liver DUE TO (c) 30 Days INTERVAL BETWEEN ONSET AND DEATH 30 Days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) this hospital attended the deceased from March 12, 1967 , to April 11, 1967 , that (1) was last saw the deceased alive on April 11, 1967 , and that death occurred at 1:45 PM , from causes and on the date stated above.			
22a. SIGNATURE Samuel J. Sugar		22b. DATE SIGNED 4-12-67	
22c. PHYSICIAN'S NAME (Type) Samuel J. Sugar, M.D.		22d. ADDRESS 4637 Eastern Ave. Washington, D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4/14/67	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Com.	23d. LOCATION (City or Town) (County) (State) Wash., D.C.
24. FUNERAL DIRECTOR Home Inc. Nalley's Funeral Maryland		25a. REC'D BY REGISTRAR DATE 4-17-1967	25b. REGISTRAR'S SIGNATURE J. Charles Young



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

05587

05587

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY Prince George's b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Cheverly c LENGTH OF STAY IN b 4 hours d NAME OF HOSPITAL, OR INSTITUTION (If not in hospital give street address) Prince George's Hospital		2 USUAL RESIDENCE (Where deceased lived, if institution Residence, list institution) a STATE Maryland b COUNTY Prince George's c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Carmody Hills d STREET ADDRESS 7403 C Street e RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Alfred Benjamin Clark		4 DATE OF DEATH Month Day Year April 30 19 67	
5 SEX male	6 COLOR OR RACE Negro	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 12-22-47
9 AGE (in years lost birthday) 19 yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian	
10b KIND OF BUSINESS OR INDUSTRY INDUSTRY		11 BIRTHPLACE (State or foreign country) Maryland	
12 CITIZEN OF WHAT COUNTRY? USA		13 FATHER'S NAME Alfred B. Clark, Sr.	
14 MOTHER'S MAIDEN NAME Clarice Smith		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or Unknown) (If yes give war or dates of service) NO	
16 SOCIAL SECURITY NO 216-50-5134		17 INFORMANT Alfred B. Clark, Sr. Address Same as 2d.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Laceration of brain Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Right pneumothorax DUE TO (c) Trauma - auto accident		INTERVAL BETWEEN ONSET AND DEATH 4 hours 4 hours 4 hours	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a EXTERNAL CAUSE WAS PRINCIPAL OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/> PRINCIPAL <input type="checkbox"/> CONTRIBUTING		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Driver of car which ran off road and collided with cement	
20c TIME OF INJURY Month, Day, Year 3:45 AM 4-30-67		20d PLACE OF INJURY (Home, farm, street, etc.) Ritchie-Mariboro Rd. s. of Whitfield Rd. P.G.	
21 I certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe, M.D.		22. DATE SIGNED 4-30-67	
EXAMINER'S NAME (Type) John Kehoe, M.D.		23a REC'D BY REG STRAR Charles Judge	
23b DATE THEREOF 5-3-67		23c NAME OF CEMETERY OR CREMATORY Resurrection Cem. Clinton Md	
23d LOCATION (City or Town) (County) (State) Rollins Funeral Home 4339 - Hunt Pl		23e REG STRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reattach carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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3
MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05588

CERTIFICATE OF DEATH

05588

1 PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYATTSVILLE			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SEAT PLEASANT		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HYATTSVILLE NURSING HOME				d. STREET ADDRESS 6315 FIELD STREET		e. IS RES. DENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First ELIZABETH Middle O. Last CLARK				4. DATE OF DEATH Month APRIL Day 26 Year 19 67			
5 SEX FEMALE		6 COLOR OR RACE WHITE		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPT. 14, 1874	
9 AGE (In years lost birthday) 92 yrs		10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) WASHINGTON D. C.	
13. FATHER'S NAME GEORGE WHITE				14. MOTHER'S MAIDEN NAME ISABELLE PIERCE			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO				16. SOCIAL SECURITY NO		17. INFORMANT Address IRENE E. OLIVER 6315 FIELD STREET SEAT PLEA	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction 1201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Thrombosis DUE TO (c) Arteriosclerotic Heart Disease						INTERVAL BETWEEN ONSET AND DEATH sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7-10 , 1967, to 4-26 , 1967, that (I) (we) last saw the deceased alive on 4-24 , 1967, and that death occurred at 6:00 M, from causes and on the date stated above.							
22a SIGNATURE Donald C. Edgren				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b DATE SIGNED 4-26-67	
22c PHYSICIAN'S NAME (Type) DONALD C. EDGREN				22d ADDRESS Hyattsville, Md.			
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b DATE THEREOF 4/20/67		23c NAME OF CEMETERY OR CREMATORY CONGRESSIONAL CEMETERY		23d LOCATION (City or Town) (County) (State) WASHINGTON D. C.	
24. FUNERAL DIRECTOR ROBERT E. WILHELM FUNERAL HOME 4308 SUTLAND ROAD, SUTLAND, MARYLAND				25a REC'D BY REGISTRAR DATE MAY 1 1967		25b REGISTRAR'S SIGNATURE Charles J. Jones	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

05589

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY (In weeks) 3 weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park		d. STREET ADDRESS 9736 52nd. Avenue	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Helena SMITH Cleveland				4. DATE OF DEATH Month 4 Day 20 Year 19 67			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-1-1898		9. AGE (In years last birthday) 68 yrs	10. IF UNDER 1 YEAR Months 1 Days 10 Hours 15 Min 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) NEW YORK		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME ADELBERT SMITH				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 578 341101		17. INFORMANT STEWART, CLEVELAND		Address 5522 KENNEDY ST RIVERDALE, MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolus DUE TO Phlebo thrombosis both femoral veins (b) From immobilization from fracture of femur. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 24 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Fell at home.					
20c. TIME OF INJURY Month, Day, Year Hour a.m. AM p.m. 3-30- 19 67		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Same as #2	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion a death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe, M.D.		EXAMINER'S NAME (Type) John Kehoe, M.D.		22. DATE SIGNED 4-21-67		Address (Street, city, town, or county) Riverdale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF APRIL 23, 1967		23c. NAME OF CEMETERY OR CREMATORY MT. HOPE CEMETERY		23d. LOCATION (City or town) (County) (State) AUGUSTA, MAINE	
24. FUNERAL DIRECTOR W.W. CHAMBERS Co. RIVERDALE, MD				25a. REC'D BY REG. STRAR APR 25 1967		25b. REG. STRAR'S SIGNATURE Charles Judge	

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if instit. an Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN lb 12 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital		d. STREET ADDRESS 8610 Cunningham Drive	
3 NAME OF DECEASED (Type or print) First Middle Last Vance E. Coffey		4. DATE OF DEATH Month Day Year April 29 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-15-94
9. AGE (In years last birthday) 72 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret Iron Worker		10b. KIND OF BUSINESS OR INDUSTRY Furniture	
11. BIRTHPLACE (Country & State, or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charlie Coffey		14. MOTHER'S MAIDEN NAME Sophronia Phipps	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 409-05-5120	
17. INFORMANT Medical Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial infarction 4-21-67 DUE TO AS HD (b) Aortic insufficiency stating the underlying cause last (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 7 hrs
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4/17, 1967, to 4/29, 1967, that (I) (we) last saw the deceased alive on 4/28, 1967 and that death occurred at 4:45 P.M. from causes and on the date stated above.			
22a. SIGNATURE F. P. Chiaramonte M.D.		22b. DATE SIGNED 4/29/67	
22c. PHYSICIAN'S NAME (Type) F. P. Chiaramonte, M. D.		22d. ADDRESS 4307 Branch Ave. Marlow Hgts., Md.	
23a. BURIAL, CREMATION, or other (Specify) Burial		23b. DATE THEREOF 5/2/67	
23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d. LOCATION (City or Town) (County) (State) Colmar Manor, P.G. Md.	
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR MAY 5 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

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J P

05591

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton</u>		c. LENGTH OF STAY IN 1b <u>Chapel Hill, Maryland</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CLINTON MEDICAL CENTER</u>		d. STREET ADDRESS <u>9155 Old Fort Road</u>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>A.</u> Last <u>Colbert</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>4</u> Year <u>1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUGUST 4 1898</u>
9. AGE (In years last birthday) yrs. <u>68</u>		10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>MR. WILLIAM COLBERT</u>		14. MOTHER'S MAIDEN NAME <u>MRS. ISABELLA HARRISON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>MRS. EMMA BOLDEN</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <u>Carcinoma splenic flexure of large bowel 6 mm.</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Vascular Accident</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>3/22</u> , 19 <u>67</u> , to <u>4/4</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4/4</u> , 19 <u>67</u> , and that death occurred at <u>7:20</u> A.M., from causes on and on the date stated above.			
22a. SIGNATURE <u>Steven Christian MD</u>		22b. DATE SIGNED <u>4/4/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>STEVEN CHRISTIAN MD</u>		22d. ADDRESS <u>1534 16th St. NW Wash. D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4--8-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Church Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Chapel Hill, Maryland</u>
24. FUNERAL DIRECTOR <u>Phonics Funeral Home, Wash. DC.</u>		25a. REC'D BY REGISTRAR DATE <u>APR 7 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05592

CERTIFICATE OF DEATH

05592

1 PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural (Glenn Dale)		c. LENGTH OF STAY IN TB 25 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital		e. STREET ADDRESS Glenn Dale Hospital	
3 NAME OF DECEASED (Type or print) James Shields Conant		4 DATE OF DEATH Month April Day 9 Year 19 67	
5. SEX male	6. COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH August 7, 1906
9 AGE (In years last birthday) 60 yrs		10 IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician		11b. KIND OF BUSINESS OR INDUSTRY Hospital	
12 BIRTHPLACE (County & State, or foreign country) Amsterdam, N.Y.		13 CITIZEN OF WHAT COUNTRY? U.S.A.	
14 FATHER'S NAME James B. Conant		15 MOTHER'S MAIDEN NAME Mary Jane Fritsch	
16 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		17 SOCIAL SECURITY NO 560-24-6775	
18 INFORMANT Ellen Conant - wife -		Address Glenn Dale Hospital	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive coronary occlusion DUE TO (b) _____ DUE TO (c) Arteriosclerotic heart disease			INTERVAL BETWEEN ONSET AND DEATH 30 minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour am Month 19 Day 19 Year 1967 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 4/9 , 19 67 , to 4/9 , 19 67 , that (I) (we) last saw the deceased alive on 4/9 , 19 67 , and that death occurred at 7:35 M., from causes and on the date stated above.			
22a. SIGNATURE Y.C. Koh M.D.		22b. DATE SIGNED April 9, 1967	
22c. PHYSICIAN'S NAME (Type) Yeong-Cheol Koh, M.D.		22d. ADDRESS Glenn Dale Hospital, Glenn Dale Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE THEREOF 4/11/67	23c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery	23d. LOCATION (City or Town) (County) (State) Amsterdam, New York
24 FUNERAL DIRECTOR Joseph Hawley Sons, Inc. Wash., D.C.		25a. REC'D BY REGISTRAR APR 12 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05593

CERTIFICATE OF DEATH

05593

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORESTVILLE		c. LENGTH OF STAY IN 1b UPPER MARLBORO		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) REGENT NURSING HOME		d. STREET ADDRESS 4720 ROBBIE DRIVE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Emelia R. Cornelison		4. DATE OF DEATH Month Apr Day 27 Year 1967			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV. 12, 1883	9. AGE (In years last birthday) 83 yrs	IF UNDER 1 YEAR Months Days Hours Mm.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) ASLAND PENNSYLVANIA	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME WILHIMINIA UNKNOWN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT HARRY CORNELISON SAME AS # 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Coronary thrombosis DUE TO 4/91 X (b) Bronchopneumonia Rt. Lower Lobe DUE TO 10 days (c) 10 days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					INTERVAL BETWEEN ONSET AND DEATH 20 min
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 7-3 , 1966 to 4-27 , 1967, that (I) (we) last saw the deceased alive on 4-27 , 1967, and that death occurred at 3:59 P.M. from causes and on the date stated above.					
22a. SIGNATURE W.B. Sheer		22b. DATE SIGNED 4-27-67		22c. PHYSICIAN'S NAME (Type) WALTER B. SHEER	
22d. ADDRESS 6400 MARLBORO PIKE SE. WASH. D.C. 20028					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 5/1/67	23c. NAME OF CEMETERY OR CREMATORY MUNCY CEMETERY	23d. LOCATION (City or town) (County) (State) MUNCY, PENNSYLVANIA		
24. FUNERAL DIRECTOR ROBERT E. WILHELM FUNERAL HOME 4308 SUITLAND ROAD, SUITLAND, MARYLAND		25a. REC'D BY REGISTRAR MAY 2 1967		25b. REGISTRAR'S SIGNATURE W. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

05594

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #2a,b,c & d Film #3489 5/23/67 pc

CERTIFICATE OF DEATH

05594

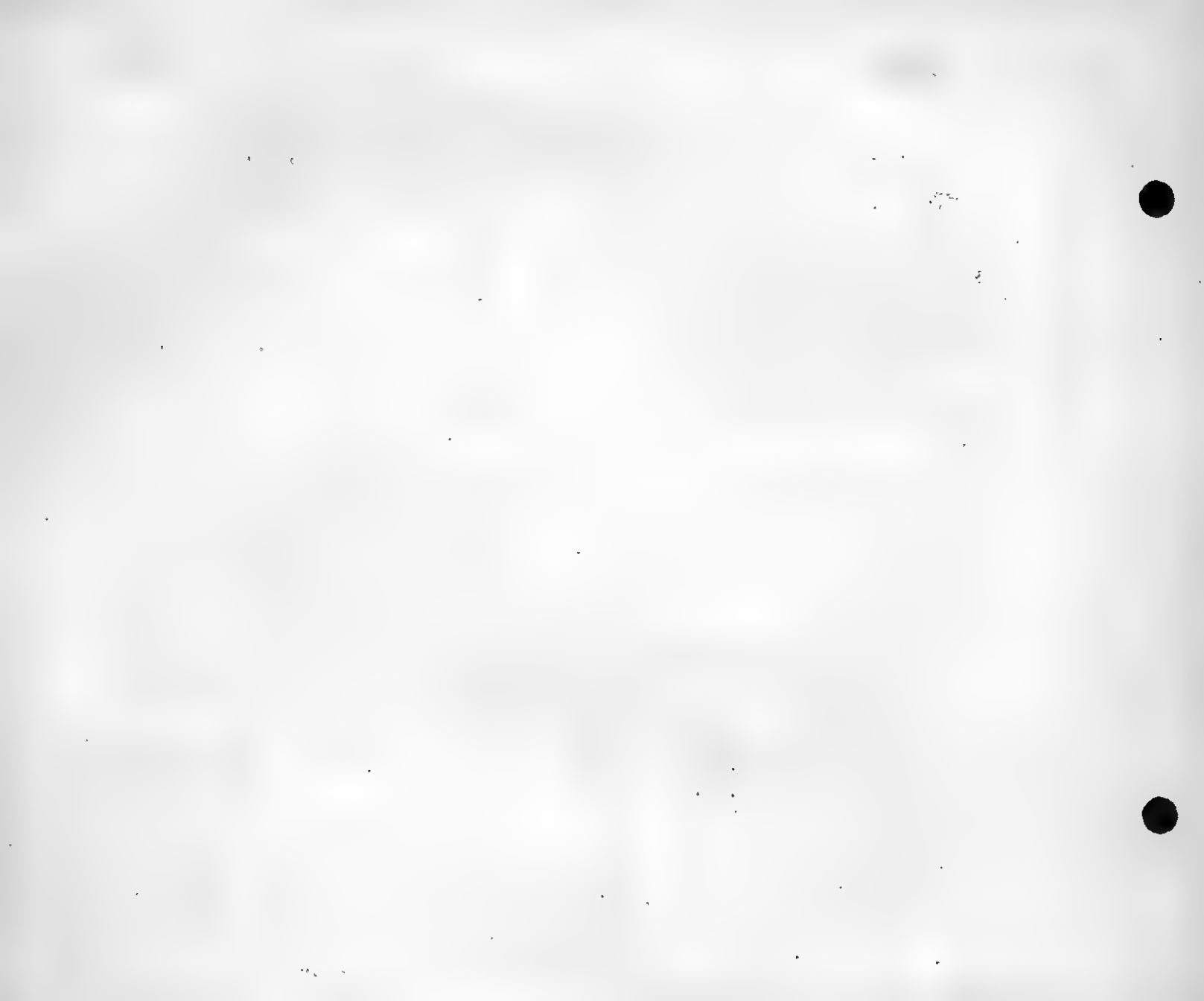
1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Ranier Hyattsville		c. LENGTH OF STAY IN Tb Wash, D.C.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Carroll Manor		e. STREET ADDRESS 2109 Ft Davis, S.E. 4922 LaSalle Rd	
3. NAME OF DECEASED (Type or print) First NELLIE Middle E. Last COVELL		4. DATE OF DEATH Month April Day 17 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 17, 1882
9. AGE (in years) 84 yrs		10. IF UNDER 1 YEAR Months 84 Days 84 Hours 84 Min 84	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Emerson		14. MOTHER'S MAIDEN NAME Violet Kraft	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO	
17. INFORMANT Rev. Frederick Bloom-Rockville, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) acute myocardial infarction DUE TO (b) arteriosclerotic heart disease DUE TO (c) diabetes mellitus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH 4 yr
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus			
19. WAS A TOLPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from April 11, 1967 , to April 17, 1967 , that (I) (we) later saw the deceased alive on April 4, 1967 , and that death occurred at 6:40 P.M. from causes and on the date stated above.			
22a. SIGNATURE Timothy F O'Donovan M.D.		22b. DATE SIGNED 4/17/67	
22c. PHYSICIAN'S NAME (Type) Timothy F. O'Donovan		22d. ADDRESS 4400 S. Randolph Rd. Rockville, Md.	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial	23b. DATE THEREOF 4/19/67	23c. NAME OF CEMETERY OR CREMATORY Mt. Comfort	23d. LOCATION (City or Town) (County) (State) Alexandria, Va.
24. FUNERAL, BURIAL Lyson Wheeler Funeral Home-1331 Rockville Pike, Rockville, Md.		25a. REC'D BY REGISTRAR APR 19 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
05595											
1. PLACE OF DEATH a. COUNTY Prince George MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland				c. LENGTH OF STAY IN 1b 5 Months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suitland Nursing Home						d. STREET ADDRESS 4013 8th Street N.E.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Catherine R Cox			First Middle Last			4. DATE OF DEATH April 8 1967			Month Day Year		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-27-1883		9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Thomas Elliott						14. MOTHER'S MAIDEN NAME Rose Trapp					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO. 579-52-4439		17. INFORMANT Levi Cox Same as # 2					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diabetes Mellitus DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Sept 1966 to 8 Apr 1967, that (I) (we) last saw the deceased alive on 7 Apr 1967, and that death occurred at 5:42 M, from the causes and on the date stated above.											
22a. SIGNATURE J. H. Thibadeau						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) J. H. Thibadeau						22d. ADDRESS 3112 Alta Ave. S.E. S.C. 20020					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-10-1967		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln				23d. LOCATION (City, town or county) (State) Prince George Co Md			
24. FUNERAL DIRECTOR Robert A. Mattingly						ADDRESS 131-11 W. 2288 D.C.			25a. REC'D BY REGISTRAR DATE APR 10 1967		
									25b. REGISTRAR'S SIGNATURE Charles Judge		



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05596

05596

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		d. STREET ADDRESS Rt. 2, Box 119	
3 NAME OF DECEASED (Type or print) First Middle Last Frank Thomas Crampton		4 DATE OF DEATH Month Day Year 4 13 19 67	
5 SEX male	6 COLOR OR RACE white	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 21 Jan. 1908
9 AGE (In years last birthday) 58		IF UNDER 1 YEAR Months Days Hours Min. 19 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY GARDINER	
11 BIRTHPLACE (State and foreign country) WASH. D. C.		12 CITIZEN OF WHAT COUNTRY? U. S. A.	
13 FATHER'S NAME JOHN W. CRAMPTON		14 MOTHER'S MAIDEN NAME CORA PENNIFIELD	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WWII		16 SOCIAL SECURITY NO 578-05-3421	
17 INFORMANT MRS. CRAWFORD WILLIAMS, WALDORF, MD		Address RT 2 Box 119	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH minutes over 7 mo.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH; BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes - over 15 years.			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe		22. DATE SIGNED 4-14-67	
EXAMINER'S NAME (Type, John Kehoe, M.D., Riverdale, Md.)		Address (Street, city, town or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 4-17-67	23c. NAME OF CEMETERY OR CREMATORY TRINITY MEM. GARDENS	23d. LOCATION (City or town) (County) (State) WALDORF, MARYLAND
24. FUNERAL DIRECTOR HUNT FUNERAL HOME, WALDORF, MD.		25a. REC'D BY REGISTRAR APR 20 1967	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05597

CERTIFICATE OF DEATH

05597

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forestville		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant		16	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Regent Nursing Home 8100--Marlboro Pike SE				d. STREET ADDRESS 512--Rollins Ave., SE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BARBARA L. CRISTOFANI				4. DATE OF DEATH Month April Day 5th Year 1967			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 28-1973	9. AGE (In years last birthday) yrs 93	IF UNDER 1 YEAR Months Days Hours Mm.		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Hanover, Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Michael Lonce				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Katharine A. Keller Address Same as Item #2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO CORONARY INSUFFICIENCY (b) GENERALIZED ARTERIOSCLEROSIS DUE TO 5-10 yrs (c) YES Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						INTERVAL BETWEEN ONSET AND DEATH 1 HOUR	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11 , 1960, to 4/5 , 1967, that (I) (we) just saw the deceased alive on 4/5 1967, and that death occurred at 3:30 P.M. from causes and on the date stated above.							
22a. SIGNATURE Thomas F. Cullen				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 4/5/67	
22c. PHYSICIAN'S NAME (Type) Thomas F. Cullen MD				22d. ADDRESS 5103 MARLBORO ROAD, SE 104C			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 8-1967		23c. NAME OF CEMETERY OR CREMATORY St. Josephs Cemetery		23d. LOCATION (City or Town) (County) (State) Hanover, Pennsylvania	
24. FUNERAL DIRECTOR Simpsons Bros				ADDRESS Simpsons Bros. 1661-Good Hope Rd SE Wash DC		25a. REC'D BY REGISTRAR APR 7 1967	
				25b. REGISTRAR'S SIGNATURE J. Charles Judge			

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05598

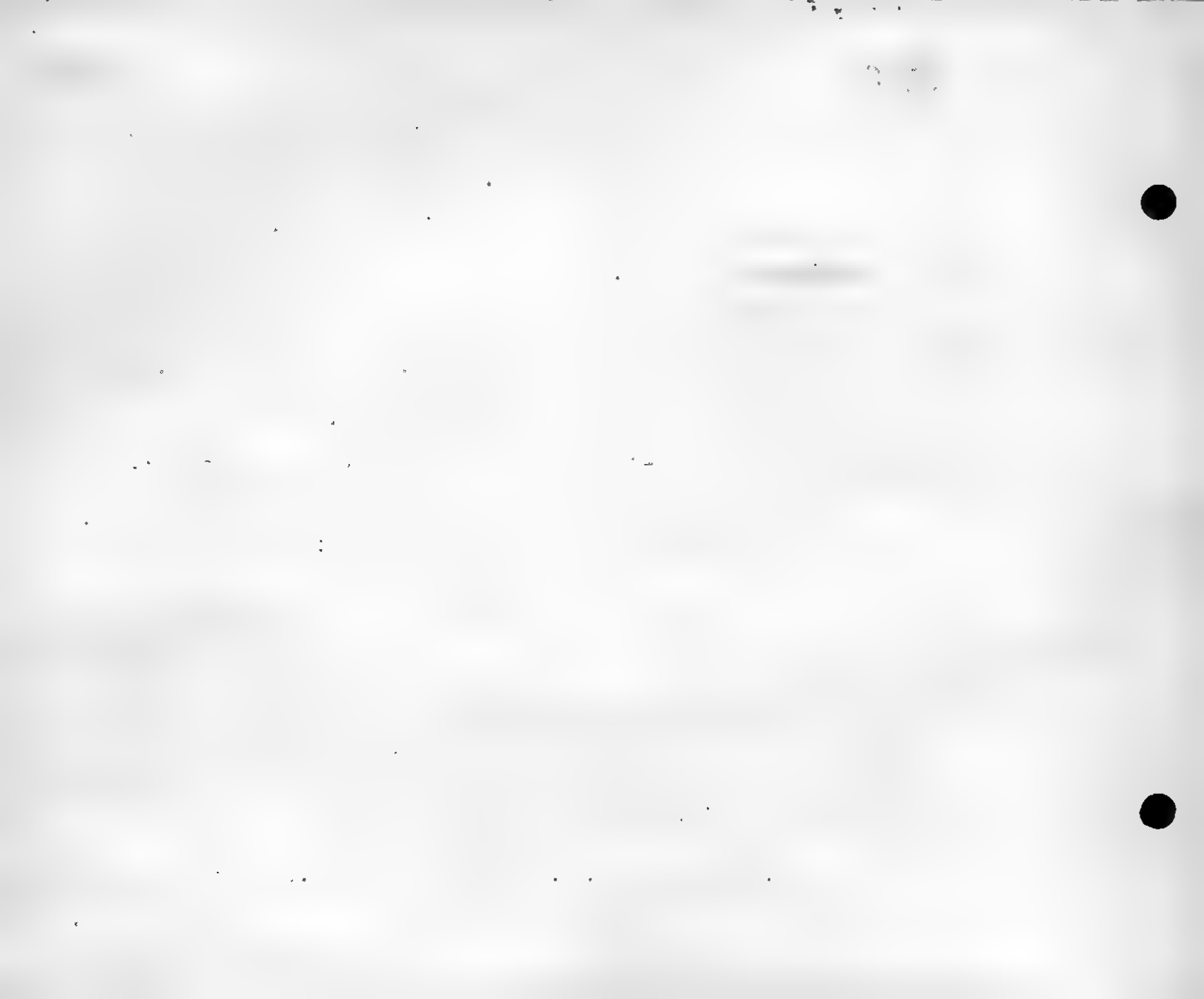
CERTIFICATE OF DEATH

05598

1 PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN lb Approx. 2 wks d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before adm ssion) a. STATE Maryland b. COUNTY Pr. Geo. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier d. STREET ADDRESS 3716 - 37th St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last Edna W. Davison		4. DATE OF DEATH Month Day Year April 12 19 67	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 4/19/1893
9. AGE (In years last birthday) yrs. 73		10. IF UNDER 1 YEAR Months Days Hours Min 3 weeks	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Health, Educ. & Welfare		10b. KIND OF BUSINESS OR INDUSTRY Penna.	
11. BIRTHPLACE (County & State, or foreign country) U.S.A.		12. CIT ZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Davis N. Wiley		14. MOTHER'S MAIDEN NAME Hanna L. Eshbaugh	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 578-32-7670	
17. INFORMANT Mr. Robert M. Davison - (Son)		Address 10814 - Jewett St., Silver Spring, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cerebrovascular disease DUE TO (c) 3 weeks		INTERVAL BETWEEN ONSET AND DEATH 3 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3/25, 1967 to 4/12, 1967 , that (I) (we) last saw the deceased alive on 4/12/67 19, and that death occurred at M , from causes and on the date stated above.			
22a. SIGNATURE R.A. Mendelsohn		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Robert A. Mendelsohn, M. D.		22d. ADDRESS 1012 Spring St., Silver Spring, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/15/67	
23c. NAME OF CEMETERY OR CREMATORY Meade Chapel Cemetery		23d. LOCATION (City or Town) (County) (State) Brookville, Penna.	
24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.		25a. REC'D BY REGISTRAR Apr 17 1967	
ADDRESS Mt. Rainier, Maryland		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05599

CERTIFICATE OF DEATH

05599

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u> c. LENGTH OF STAY IN lb <u>17 days</u>				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>			
3. NAME OF DECEASED (Type or print) <u>Emma Mary Davidson</u> First Middle Last d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eugene Leland Mem Hosp</u> e. STREET ADDRESS <u>1007 10th Street</u> f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
4. DATE OF DEATH Month <u>4</u> Day <u>14</u> Year <u>1967</u>		5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-3-88</u> 9. AGE (In years lost by day) <u>78</u> yrs 10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> 11. BIRTHPLACE (County & State, or foreign country) <u>California</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Charles D. Webster</u> 14. MOTHER'S MAIDEN NAME <u>Emma Erikson</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>daughter Jean Kreeg</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> (b) <u>GEN. ARTERIOSCLEROSIS</u> (c) <u>UNKNOWN</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH <u>17 DAYS</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		20g. (County)		20h. (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>3 28</u>, 19<u>67</u>, to <u>4 14</u>, 19<u>67</u>, that (I) (we) last saw the deceased alive on <u>4-13</u>, 19<u>67</u>, and that death occurred at <u>6:45</u> A.M., from causes and on the date stated above.							
22a. SIGNATURE <u>C. J. Houmann</u> M.D.		22b. DATE SIGNED <u>4-14-67</u>		22c. PHYSICIAN'S NAME (Type) <u>C. J. HOUMANN</u>			
22d. ADDRESS <u>RIVERDALE MD</u>		23a. BURIAL, CREMATION, REMOVAL (Specify)					
23b. DATE THEREOF <u>April 14, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Ignace Cemetery</u>		23d. LOCATION (City or Town) <u>Calver Mary - P.G. Md.</u>			
24. FUNERAL DIRECTOR <u>Butt & Bonaldy Laurel Md.</u>		25a. READ BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			
DATE <u>APR 20 1967</u>							

FOR STATE
HEALTH DEPT.

05600

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05600

1 PLACE OF DEATH a COUNTY PRINCE GEORGES MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if inst tut on Residence before adm ssion) a STATE MARYLAND b COUNTY PRINCE GEORGES	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SUTLAND		c LENGTH OF STAY IN lb DOA	
d NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) ANDREWS AIR FORCE BASE HOSPITAL		d STREET ADDRESS 9820 ALLENTOWN ROAD	
3 NAME OF DECEASED (Type or print) First Middle Last EARL E DAY		4 DATE OF DEATH Month Day Year APRIL 6 19 67	
5 SEX MALE	6 COLOR OR RACE WHITE	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH NOV. 30, 1910
9 AGE (n years lost birthday) yrs 56		10 IF JADER 1 YEAR Months Days 19 67	
11 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INSTALLER		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME ERNEST E. DAY		14 MOTHER'S MAIDEN NAME HATTIE G. STAMP	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO	
17 INFORMANT ERNEST E. DAY 3009 8th St. S.E. WASH. D.C.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4x01 Coronary Thrombosis (b) Coronary Sclerosis (c) Hypertensive C.V. Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } INTERVAL BETWEEN ONSET AND DEATH 3 years			
PART II OTHER SIGNIFICANT CONDITIONS CONTR. B. TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE D. O. Walth		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME DAYTON O Walth		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 4-6-67	
Address (Street, city, town, or county)			
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b DATE THEREOF 4/8/67	23c NAME OF CEMETERY OR CREMATORY WASHINGTON NATIONAL	23d. LOCATION (City or Town) (County) (State) PRINCE GEORGES, MARYLAND
24. FUNERAL DIRECTOR ROBERT E. WILHELM FUNERAL HOME 4308 SUTLAND ROAD, SUTLAND, MARYLAND		25a. REC'D BY REGISTRAR APR 10 1967	
		25b. REGISTRAR'S SIGNATURE [Signature]	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05601

CERTIFICATE OF DEATH

05601

1 PLACE OF DEATH a. COUNTY <i>Prince Georges Co., MARYLAND</i>		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Pa.</i> b. COUNTY <i>CLAY</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Clinton</i>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>MARKLEYSBURG, Pa.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Southern Md. Medical Center</i>		d. STREET ADDRESS <i>RT # 1 - Box 20A</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) <i>Harold J. Denver</i>		4 DATE OF DEATH Month <i>April</i> Day <i>16</i> Year <i>1967</i>	
5 SEX <i>M</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8/31/1896</i>
9 AGE (In years last birthday) <i>70 yrs</i>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>RETIRED</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>CARPENTER</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>NEW JERSEY</i>		12. CITIZEN OF WHAT COUNTRY? <i>AMERICAN</i>	
13. FATHER'S NAME <i>JACK H. DENVER</i>		14. MOTHER'S MAIDEN NAME <i>GERTRUDE MILLER</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO	
17. INFORMANT <i>MARY F. DENVER</i>		Address <i>J. M. F.</i>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Hypertension, moderate</i> DUE TO (c) <i>Coronary Artery Disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>4-11-67</i> , 19 <i>67</i> , to <i>4-16-67</i> , that (I) (we) last saw the deceased alive on <i>4-16-67</i> , and that death occurred at <i>2:04 A.M.</i> , from causes and on the date stated above.			
22a. SIGNATURE <i>Alfred K. Lapina, M.D.</i>		22b. DATE SIGNED <i>4/16/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>ALFRED K. LAPINA</i>		22d. ADDRESS <i>CLINTON, MD</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>buried</i>		23b. DATE THEREOF <i>APR 18-67</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>St. James Cemetery</i>		23d. LOCATION (City or town) (County) (State) <i>Clinton, MD</i>	
24. FUNERAL DIRECTOR <i>St. James Cemetery</i>		25a. REC'D BY REGISTRAR <i>W. A.</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles George</i>		25c. DATE <i>APR 19 1967</i>	

05602

CERTIFICATE OF DEATH

05602

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)				c. LENGTH OF STAY IN lb 7 days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital				d. STREET ADDRESS 323 17th Street, S.E.			
3. NAME OF DECEASED (Type or print) Bennie Dobson				4. DATE OF DEATH Month April Day 12 Year 19 67			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-29-1896	9. AGE (In years last birthday) 70 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 24 HRS. Hours M.n.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY - - -		11. BIRTHPLACE (County & State or foreign country) South Carolina	
13. FATHER'S NAME Isaac Dobson				14. MOTHER'S MAIDEN NAME Rena Mules			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 609-14-4505		17. INFORMANT Decedent	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable pulmonary embolism 4200 DUE TO (b) arteriosclerotic heart disease with congestive heart failure, decompensated DUE TO (c) generalized arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH 1 day unknown unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pulmonary bullous emphysema and fibrosis; multiple decubiti.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that he (this hospital) attended the deceased from 4/5 9:45 P.M. 4/12 , 1967, that he (we) last saw the deceased alive on 4/12 , 1967, and that death occurred at _____, from causes and on the date stated above.							
22a. SIGNATURE <i>Moe Weiss</i>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4/12/67	
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.				22d. ADDRESS Glenn Dale Hospital Glenn Dale, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 4-17-67		23c. NAME OF CEMETERY OR CREMATORY HARMONY MEMORIAL PARK		23d. LOCATION (City or Town) (County) (State) PRINCE GEORGE'S COUNTY, MD.	
24. FUNERAL DIRECTOR <i>Princes Funeral Home</i>				ADDRESS <i>301 N. 1st St.</i>		25a. REC'D BY REGISTRAR APR 18 1967	
				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal. Any event, within 72 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05603

CERTIFICATE OF DEATH

05603

1 PLACE OF DEATH o. COUNTY <u>PR. GEORGE'S</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton, Md.</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Southern Maryland Hospital</u>		d. STREET/ADDRESS <u>Rt. 1-Box 152</u>	
3 NAME OF DECEASED (Type or print) <u>JOSEPH DORSEY</u>		4 DATE OF DEATH <u>April 8-1967</u>	
5 SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. AGE (In years last birthday) <u>71</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) <u>Chas. Co. Maryland</u>		12 CITIZEN OF WHAT COUNTRY?	
13 FATHER'S NAME <u>Unknown William Leonard</u>		14 MOTHER'S MAIDEN NAME <u>Rachel Dorsey</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO <u>226-24-8904</u>	
17 INFORMANT <u>Mary C. Dorsey</u>		Address <u>Same as above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Collapse</u> DUE TO <u>Diabetes Mellitus advanced</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Pancreatic Hepatic Disease</u> DUE TO <u>Pancreatic Hepatic Disease</u> (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3-16, 1967</u> to <u>4-8, 1967</u> that (II) (we) lost saw the deceased alive on <u>4-8, 1967</u> and that death occurred at <u>7:30 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Alfred R. Lapin M.D.</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>ALFRED R. LAPIN</u>		22d. ADDRESS <u>CLINTON, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Apr. 14/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary Church Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Bryantown Chas. Co. Md.</u>	
24. FUNERAL DIRECTOR <u>Marcell Adams Aquasco, Md.</u>		25a. REC'D BY REGISTRAR <u>gcharles Judge</u>	
25b. REGISTRAR'S SIGNATURE		DATE <u>APR 17 1967</u>	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05604

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05604

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Landover Hills	
c. LENGTH OF STAY IN 1b DOA		d. STREET ADDRESS 7016 Taylor St.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First William Middle Allen Last Edens		4 DATE OF DEATH Month 4 Day 10 Year 19 67	
5 SEX male	6 COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 2 July 1897
9 AGE (in years last birthday) 69		F UNDER 1 YEAR Months Days HOURS Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Traffic Manager		10b. KIND OF BUSINESS OR INDUSTRY Trailway Bus co	
11 BIRTHPLACE (State or foreign country) Tennessee		12 CITIZEN OF WHAT COUNTRY? U S A	
13 FATHER'S NAME Samuel Edens		14. MOTHER'S MAIDEN NAME Nina Kinningham	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes WW1		16 SOC. A. SECURITY NO 578 05 7020	
17 INFORMANT Beatrice G Edens		Address Landover Hills, Md.	

18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH minutes over 3 yrs.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe M.D.	CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 4-10-67
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town or county)	
23a. BURIAL, CREMATION, REMOVAL, SPECIAL	23b. DATE THEREOF April 12, 1967	23c. NAME OF CEMETERY OR INTERMENT Ft Lincoln Cemetery	23d. LOCATION (City or town) (County) (State) Colmar Manor, Pro Geo Md.
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.		25a. REC'D BY REG. STRAR APR 14 1967	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10M3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05605

05605

1 PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale c. LENGTH OF STAY IN 1b 4 hrs. 5 min.		2 USUAL RESIDENCE (Where deceased resided if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital		d. STREET ADDRESS 3107 Windom Road	
3 NAME OF DECEASED (Type or print) Amelia B. Farley		4 DATE OF DEATH Month 4 Day 10 Year 1967	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 19 April 1912
9 AGE (In years lost birthday) yrs 54		10 UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home maker		10b. KIND OF BUSINESS OR INDUSTRY Beautician	
11 BIRTHPLACE (State or foreign country) Verona, Pennsylvania		12 CITIZEN OF WHAT COUNTRY?	
13 FATHER'S NAME James M. Barr		14 MOTHER'S MAIDEN NAME Berna A. McPherson	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO 7-10-10-10	
17 INFORMANT Mr. Dominick L. White		Address 1304 Palad Dr. St.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Gastro intestinal hemorrhage DUE TO (b) (cause undetermined) DUE TO (c) 5/10/67 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bag, etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspect an <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED 4-11-67	
ACTUAL SIGNATURE John Kehoe, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street city town or county)	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		23a. DATE OF CREMATION, REMOVAL (Specify) 4-13-1967	
23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY George Washington Cemetery, Riverdale, Md.	
23d. LOCATION (City or town) (County) (State) APR 13 1967		23e. SIGNATURE OF DEPUTY MEDICAL EXAMINER John Kehoe, M.D.	

05606

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05606

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b DOA		2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		d. STREET ADDRESS 3904 Croydon Lane	
3. NAME OF DECEASED (Type or print) Lawrence Phillip Fern		4. DATE OF DEATH Month 4 Day 23 Year 1967	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-2-1913
9. AGE (In years lost birthday) yrs 53		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DIRECTOR OF ADMINISTRATION BUREAU OF MEDICINE, U.S.	
11. BIRTH-PLACE (State or foreign country) KANSAS		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME JAMES FERN		14. MOTHER'S M.A.DEN NAME MARY Mc CORMICK	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 510-03-8952	
17. INFORMANT MAXINE J. FERN		Address SAME AS #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure DUE TO Arteriosclerotic heart disease (b) _____ DUE TO _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		INTERVAL BETWEEN ONSET AND DEATH minutes over 6 yrs.	
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kenoe, M.D.		22. DATE SIGNED 4-24-67	
EXAMINER'S NAME (Type) John Kenoe, M.D. Riverdale, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street city town or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF APRIL 24, 1967	23c. NAME OF CEMETERY OR CREMATORY WASHINGTON NATIONAL	23d. LOCATION (City or Town) (County) (State) SUITLAND, MARYLAND
24. FUNERAL DIRECTOR W. W. CHAMBERS, Co. RIVERDALE, MD		25a. REC'D BY REGISTRAR APR 28 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiners' Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18&21 Film 389
6-14-67 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05607

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05607

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, give name of institution; if admission) a. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b Washington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5810 Cleveland Street		d. STREET ADDRESS 543 23rd. Place, N.E.	
3. NAME OF DECEASED (Type or print) First Middle Last Mary Durham Fields		4. DATE OF DEATH Month Day Year 4 16 19 67	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-10-1908
9. AGE (In years last birthday) 58 yrs		10. IF UNDER 1 YEAR Months Ooys Hours Min	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		12. BIRTHPLACE (State or foreign country) North Carolina	
13. FATHER'S NAME Samuel G. Durham		14. MOTHER'S MAIDEN NAME Nancy Wyche	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. William Boggs-Sister-543 23rd		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary edema, massive DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO (c) and bronchial aspiration, mucous			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of Item 1b)	
20c. TIME OF INJURY Month Day Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John Kehoe</i>		22. DATE SIGNED 4-17-67	
EXAMINER'S NAME (Type) John Kehoe, M.D.		Address (Street, city, town, or county) Riverdale, Md.	
23a. BURIAL OR CREMATION (Specify) Burial	23b. DATE THEREOF 4/20/67	23c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial Ceme.	23d. LOCATION (City or Town) (County) (State) Maryland
24. FUNERAL DIRECTOR <i>John H. Stewart</i>		25a. REC'D BY REGISTRAR APR 20 1967	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		25c. REGISTRAR'S NAME Stewart Funeral Home-4001 Benning Road, N.E.	



05608

CERTIFICATE OF DEATH

05608

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Md. b. COUNTY Pr. Geo. Co	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier		c. LENGTH OF STAY IN 1b 63 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4206 29th Street		d. STREET ADDRESS 4206 29th Street	
3. NAME OF DECEASED (Type or print) Edward Jerome Flynn		4. DATE OF DEATH April 25 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-22-02
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Freight Conductor		10b. KIND OF BUSINESS OR INDUSTRY Penna. Railroad	11. BIRTHPLACE (County & State, or foreign country) Washington D.C.
13. FATHER'S NAME Richard Flynn		14. MOTHER'S MAIDEN NAME Margaret Mannix	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes-Navy 1915		16. SOCIAL SECURITY NO 717-07-8480	17. INFORMANT Oglethorpe St., Riverdale, Md. Ernestine Ann Flynn (daughter-in-law)
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN DEATH AND DEATH CERTIFICATE acute coronary occlusion arteriosclerosis 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 2 diabetes mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Nov 1954, to Apr 25, 1967, that (I) (we) last saw the deceased alive on Apr 4, 1967, and that death occurred at 7:15 P.M. from causes and on the date stated above.			
22a. SIGNATURE L.W. Malin		22b. DATE SIGNED 4-25-67	
22c. PHYSICIAN'S NAME (Type) L.W. MALIN M.D.		22d. ADDRESS Riverdale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4/28/67	23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Com.	23d. LOCATION (City or Town) (County) (State) Colmar Manor, Md.
24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.		25a. REC'D BY REGISTRAR MAY 1 1967	
ADDRESS Mt. Rainier Maryland		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05609

CERTIFICATE OF DEATH

05609

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY PRINCE GEORGE'S b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE c. LENGTH OF STAY IN 1b ANDREWS AIR FORCE BASE d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF HOSPITAL ANDREWS		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE'S c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE d. STREET ADDRESS VOO 1350-6 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) BENJAMIN DELAHAUF FOULOIS		4. DATE OF DEATH Month APRIL Day 25 Year 1967	
5 SEX MALE	6 COLOR OR RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	8 DATE OF BIRTH 9 DEC 1879
9 AGE (In years last birthday) 87 yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OFFICER	10b KIND OF BUSINESS OR INDUSTRY U.S. AIR FORCE
11 BIRTHPLACE (County & State, or foreign country) WASHINGTON, CONN.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME HENRY FOULOIS		14 MOTHER'S M.A.DEN NAME UNKNOWN	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes give war or dates of service) YES 1899-1935		16 SOCIAL SECURITY NO. 579-60-2054	
17 INFORMANT MARY K REEVES-GRAND NIECE		Address 2515 R ST.S.E. WASHINGTON D.C.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <input checked="" type="checkbox"/> CARDIORESPIRATORY ARREST DUE TO (b) MULTIPLE CEREBRAL INFARCTIONS DUE TO (c) CEREBROVASCULAR DISEASE			INTERVAL BETWEEN ONSET AND DEATH 6 MONTHS 6 MONTHS
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) PNEUMONIA			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 19 SEP 1966 to 25 APR 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 25 APR 1967 , and that death occurred at 4:05 PM , from causes and on the date stated above.			
22a. SIGNATURE <input checked="" type="checkbox"/> <i>Charles D Phelps</i>		22b. DATE SIGNED 25 APR 67	
22c. PHYSICIAN'S NAME (Type) CHARLES D PHELPS CAPT USAF MC		22d. ADDRESS USAF HOSPITAL ANDREWS ANDREWS AFB, WASHINGTON DC 20331	
23a BURIAL, CREMATION, REMOVAL (Specify) Removal	23b DATE THEREOF 4-27-1967	23c NAME OF CEMETERY OR CREMATORY Washington Cemetery	23d LOCATION (City or Town) (County) (State) Washington, Conn.
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. 5130 Visc. Ave. N.W. Wash. D.C.		25a REC'D BY REGISTRAR MAY 2 1967	
		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05610
05610
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE c. LENGTH OF STAY IN 1b 1 DAY d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF HOSPITAL ANDREWS		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE VIRGINIA b. COUNTY FAIRFAX c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ALEXANDRIA d. STREET ADDRESS 303 Princeton Blvd e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ROBERT F FROST		4. DATE OF DEATH Month APRIL Day 9 Year 1967	
5. SEX MALE		6. COLOR OR RACE CAU	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 21 JUN 1911	
9. AGE (In years last birthday) 55 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OFFICER		11b. KIND OF BUSINESS OR INDUSTRY U.S. AIR FORCE	
12. BIRTHPLACE (County & State, or foreign country) FORT DODGE, IOWA		13. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. FATHER'S NAME FREDERICK R FROST		15. MOTHER'S MAIDEN NAME MARY L. WILL	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES RET -1960		17. SOCIAL SECURITY NO. WIFE, SAME AS # 2	
18. INFORMANT WIFE, SAME AS # 2		Address	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. Meta static CARCINOMA DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not White at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Apr. 8, 1967 to Apr. 9, 1967 , that (I) (we) last saw the deceased alive on Apr. 9, 1967 , and that death occurred at 11:30 AM , from the causes and on the date stated above.			
22a. SIGNATURE Robert L. Mitchell		22b. DATE SIGNED 10 Apr 1967	
22c. PHYSICIAN'S NAME (Type) ROBERT L. MITCHELL, CAPT USAF MC		22d. ADDRESS USAF Hospital Andrews Andrews AFB, Wash DC 20331	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 13 April 1967	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Alexandra, Virginia Everly-Wheatley Funeral Home		25a. REC'D BY REGISTRAR APR 13 1967 25b. REGISTRAR'S SIGNATURE Charles Judge	

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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(M)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05611

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05611

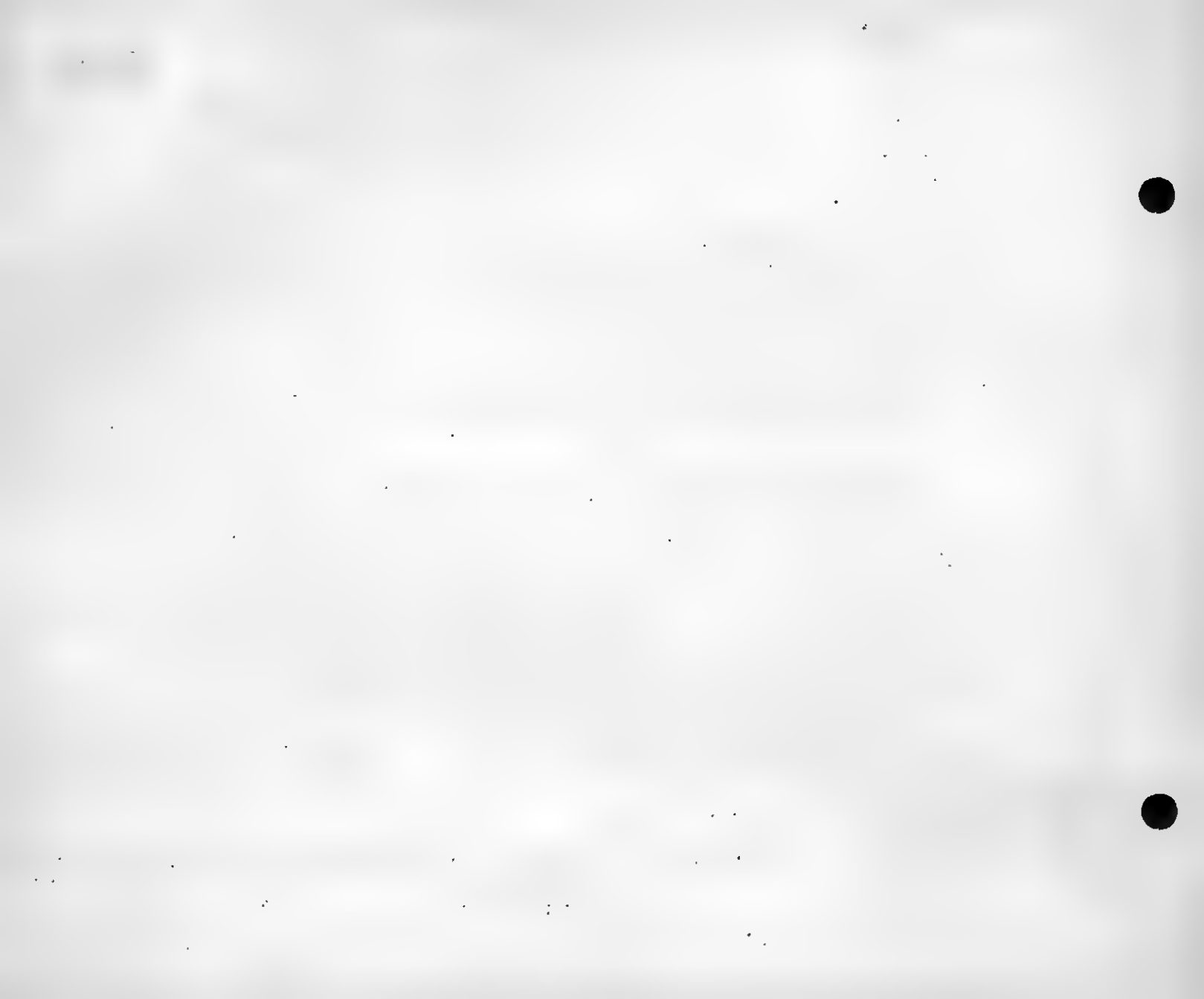
1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b DOA	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's Hospital			d. STREET ADDRESS 9425 Michael Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First Middle Last Marion Frederick Frye			4 DATE OF DEATH Month Day Year April 29 1967		
5 SEX male	6 COLOR OR RACE white	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Aug. 31, 1895		9 AGE (In years last birthday) yrs 71
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Policeman		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME William Martin Frye			14. MOTHER'S MAIDEN NAME Florence Magnolia Matthews		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO 577-56-9403		17. INFORMANT Address Allen S. Frye-1326 Canyon Rd. Silver Spring, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO (b) Arteriosclerotic heart disease DUE TO (c) 16 years					INTERVAL BETWEEN ONSET AND DEATH minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work hot While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspect on <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John Kehoe, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED 4-29-67	
EXAMINER'S NAME (Type) John Kehoe, M.D.		Address (Street and town, county) Riverside, Md.			
23a. BURIAL CREMATION REMOVAL (Specify) burial	23b. DATE THEREOF 5/3/67	23c. NAME OF CEMETERY OR CREMATORY Washington National Cem.		23d. LOCATION (City or town) (County) (State) Suitland, Md.	
24. FUNERAL DIRECTOR The S.H. Hines Company 2901 14th St. N.W. Washington, D.C.		25a. RECORDED BY REGISTRAR MAY 2 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
05613 Item #7 Film #G365 1/1/61 DC						05613					
1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE'S					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BRENTWOOD						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BRENTWOOD					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 3900 39th STREET						d. STREET ADDRESS 3900 39th STREET					
3. NAME OF DECEASED (Type or print) First Middle Last ANNA GERTRUDE GIBBONS						4. DATE OF DEATH Month Day Year APRIL 18 1967					
5. SEX FEMALE		6. COLOR OR RACE CAUCASIAN		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAY 23, 1886		9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK				10b. KIND OF BUSINESS OR INDUSTRY U.S.V.B.		11. BIRTHPLACE (County & State, or foreign country) PENNA.			12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME JOHN GIBBONS						14. MOTHER'S MAIDEN NAME TERESA HAWKS					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. NONE		17. INFORMANT MARGARET H. ROM		Address SAME AS #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Cancer DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cancer of Sigmoid Colon DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yrs. 4 yrs.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Feb. 3, 1966, to Apr. 12, 1967, that (I) (we) last saw the deceased alive on Apr. 12, 1967, and that death occurred at 10:30 P.M. from the causes and on the date stated above.											
22a. SIGNATURE Charles C. Hageage						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Apr. 19, 1967	
22c. PHYSICIAN'S NAME (Type) Charles C. Hageage M.D.						22d. ADDRESS 3308 Perry St., Mt. Rainier, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4-21-1967		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN				23d. LOCATION (City, town or county) (State) WHEATON, MARYLAND			
24. FUNERAL DIRECTOR W.W. CHAMBERS Co. RIVERDALE, Md.						25a. REC'D BY REGISTRAR DATE APR 24 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed with in 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files.

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VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05614

05614

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived) f. Institution Residence before admission) a. STATE b. COUNTY Maryland Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN TB DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital				d. STREET ADDRESS 4229 30th. Street			
3 NAME OF DECEASED (Type or print) Robert Anthony Gillis				4 DATE OF DEATH Month 4 Day 3 Year 1967			
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12 Nov. 24-Oct. 1918		9 AGE (In years last birthday) yrs 48		10 IF UNDER 1 YEAR Months 3 Days 19 Hours 67 Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Salesman		10b. KIND OF BUSINESS OR INDUSTRY Milestone Liq.		11. BIRTHPLACE (State or foreign country) St. Joseph, Missouri		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WWII		16. SOCIAL SECURITY NO. 494-30-7526		17. INFORMANT Mrs. Virginia Gillis (above address) (wife)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) INTERVAL BETWEEN ONSET AND DEATH minutes over 3 mo.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe, M.D. Riverdale, Md.				22. DATE SIGNED 4-5-67			
23a. BURIAL CREMATION REMOVAL Burial		23b. DATE THEREOF 4/7/67		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Com.		23d. LOCATION (City or town) (County) (State) Colmar Manor, Md.	
24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.				25. REC'D BY REGISTRAR APR 10 1967		25b. REGISTRAR'S SIGNATURE Charles J. J...	

MEDICAL CERTIFICATION



05615

CERTIFICATE OF DEATH

05615

1 PLACE OF DEATH a. COUNTY Prince George MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE Maryland b COUNTY Prince George	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c LENGTH OF STAY IN 1b Hyattsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4208 Farragut Street		d. STREET ADDRESS 4208 Farragut Street	
3 NAME OF DECEASED (Type or print) CATHARINE W. GLOVER		4 DATE OF DEATH April 26, 1967	
5 SEX Female	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 9, 1882
9 AGE (In years birthday) yrs 85		IF UNDER 1 YEAR Months Days Hours Min. 19	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11 BIRTHPLACE (County & State, or foreign country) New York		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13 FATHER'S NAME Judson Wakeman		14 MOTHER'S MAIDEN NAME Catharine Conklin	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 525 54 4048	
17. INFORMANT Mrs. Catharine Marsden Same as #2 (daughter)		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Coronary artery arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH 10 yrs	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 11-18 , 19 64 , to 4-26 , 19 67 , that (I) (we) last saw the deceased alive on 4-25 19 67 , and that death occurred at 7 A.M. from causes and on the date stated above.			
22a SIGNATURE R.C. Kirchner		22b. DATE SIGNED 4-26-67	
22c. PHYSICIAN'S NAME (Type) R.C. KIRCHNER		22d ADDRESS 6480-N.H. Ave - TAKOMA PARK Md	
23a BURIAL, CREMATION, or other disposal (Specify) Burial	23b. DATE THEREOF 4/28/67	23c. NAME OF CEMETERY OR CREMATORY Pohick Church	23d LOCATION (City or Town) (County) (State) Lorton Va.
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE APR 28 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reattach carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05616

05616

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Capitol Heights		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Capitol Heights	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 605 59th Avenue		d. STREET ADDRESS 605 59th Avenue	
3. NAME OF DECEASED (Type or print) First William Middle A Last Godbout		4. DATE OF DEATH Month April Day 7 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-10-1889
9. AGE (In years last birthday) 77 yrs		10. IF UNDER 1 YEAR Months 7 Days 16 Hours 11 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (County & State, or foreign country) Canada		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Godbout		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT Helen L. Fillmann 603 71st Ave. Seat Pleasant		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Pulmonary Hemorrhage DUE TO (b) Adenocarcinoma of left lung DUE TO (c) 2 years		INTERVAL BETWEEN ONSET AND DEATH 1 hour	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Nov 1942 , to Apr. 7, 1967 , that (I) (we) last saw the deceased alive on April 7, 1967 , and that death occurred at 9:30 AM , from causes and on the date stated above.			
22a. SIGNATURE W H Clements		22b. DATE SIGNED April 7, 1967	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4-10-1967	23c. NAME OF CEMETERY OR CREMATORY Washington National	23d. LOCATION (City or Town) (County) (State) Suitland Maryland
24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home 4308 Suitland Road Suitland Maryland		25a. REC'D BY REGISTRAR APR 11 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05617

05617

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY P. G.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brandywine		c. LENGTH OF STAY IN 1b unknown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brandywine			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Residence, Box 276 A, Rt 2				d. STREET ADDRESS 276A Route 2 Brandywine		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Gladys Middle Melvina Last Graff		4. DATE OF DEATH Month 4 Day 24 Year 1967					
5. SEX female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 30, 1892	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Oeltaville, Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Aaron Jackson				14. MOTHER'S MAIDEN NAME Melvina (unknown)			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT 1301 Apperell Rd. Mrs. Ella L. Burns Severna Park, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-vascular accident 481X DUE TO (b) Acute Grapical illness Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) VOMITING, PERNICIOUS, 3 DAYS						INTERVAL BETWEEN ONSET AND DEATH 2 MIN.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4/17, 1967 to 4/22/67, that (I) (we) last saw the deceased alive on 4/22/67, and that death occurred at 6:30 PM, from the causes and on the date stated above.							
22a. SIGNATURE Robert W. Markle M.D.				22b. DATE SIGNED 4/24/67		22c. PHYSICIAN'S NAME (Type) Robert W. Markle	
22c. PHYSICIAN'S NAME (Type) Robert W. Markle		22d. ADDRESS Waldorff, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/28/67		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem'l Park		23d. LOCATION (City, town or county) (State) Glen Burnie, Md.	
24. FUNERAL DIRECTOR R.V. SINGLETON,				25a. REC'D BY REGISTRAR DATE APR 28 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge	



05618

CERTIFICATE OF DEATH

05618

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>PRINCE GEORGE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BRANDYWINE</u>		c. LENGTH OF STAY IN Tb	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>PINE VIEW GARDENS</u>		d. STREET ADDRESS <u>CLINTON, MD.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>GRAHAM FRANCIS Arlee Graham</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>21</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>NE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-27-89</u>
9. AGE (In years last birthday) <u>77</u> yrs		10. IF UNDER 1 YEAR Months <u>21</u> Days <u>21</u> Hours <u>21</u> Min <u>21</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>COOPER, MARY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO <u>578-388544B</u>	
17. INFORMANT <u>GROSS, LOUISE</u>		Address <u>BRANDYWINE, MD.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiovascular Collapse</u> DUE TO (b) <u>Coronary occlusion</u> DUE TO (c) <u>Atherosclerotic Cardiovascular disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4-21, 1967</u> , to <u>4-21, 1967</u> , that (I) (we) last saw the deceased alive on <u>4-21, 1967</u> , and that death occurred approx. <u>1:30 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Alfred R. Lapin, M.D.</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>ALFRED R. LAPIN, M.D.</u>		22d. ADDRESS <u>CLINTON, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-24-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Peter's Ch. Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Malden, Ches. Co. Md.</u>	
24. FUNERAL DIRECTOR <u>Marcell Adams Agnace, Md.</u>		25a. REC'D BY REGISTRAR <u>APR 26 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

05619

CERTIFICATE OF DEATH

05619

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1 PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE Georges</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CLINTON</u>		c. LENGTH OF STAY IN 1b <u>Berkshire</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Pine View Gardens Health Care</u>		d. STREET ADDRESS <u>7316 Hamford St</u>	
3 NAME OF DECEASED (Type or print) <u>Estelle N Grant</u>		4 DATE OF DEATH <u>4</u> Month <u>13</u> Day <u>19</u> Year <u>67</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-20-91</u> 9 AGE (In years last birthday) <u>75</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. K.NO OF BUSINESS OR INOUSTRY	
11 BIRTHPLACE (County & State, or foreign country) <u>Philadelphia, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WILLIAM R. DUBOIS</u>		14. MOTHER'S MAIDEN NAME <u>Cornelia Van Dusen</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>JAMES VERNON</u>		Address <u>WASH. 20031</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO <u>Chronicity of ureters - bilateral</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>3 mon</u> (b) <u></u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 mon</u>	
PART II OTHER SIGNIFICANT CONOITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Anemia, hypochromic perne</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACC DENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>2-27</u> , 19 <u>67</u> , to <u>4-13</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4-13</u> , 19 <u>67</u> , and that death occurred at <u>4:30 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Alfred R. Lapin, MD.</u>		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) <u>ALFRED R. LAPIN, MD.</u>		22d. ADDRESS <u>CLINTON, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>4-17-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>WASH. NATIONAL</u>	23d. LOCATION (City or Town) (County) (State) <u>PRINCE GEORGES MD.</u>
24. FUNERAL DIRECTOR <u>Robert E. Withelpm</u>		25. DEED BY REGISTRAR <u>APR 17 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>
4308 SUITLAND Rd SUITLAND MD.			

CERTIFICATE OF DEATH

05620

05620

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brantwood</u>		c. LENGTH OF STAY IN 1b <u>2 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges Memorial Hospital</u>		d. STREET ADDRESS <u>1506 Parker Street</u>	
3. NAME OF DECEASED (Type or print) <u>George H Green</u>		4. DATE OF DEATH Month <u>4</u> Day <u>19</u> Year <u>67</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-8-95</u>
9. AGE (In years last birthday) <u>71</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>JEREMIAH GREEN</u>		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-01-0280</u>	
17. INFORMANT <u>Dr. L. W. Malin</u> Address <u>Hospital at Brantwood</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Failure</u> DUE TO <u>atherosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>General arterio-sclerotic condition</u> (b) <u>General arterio-sclerotic condition</u> (c) <u>General arterio-sclerotic condition</u>			INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Stomach</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF MEDICAL EXAMINATION Hour a.m. <u>19</u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Feb</u> , 19 <u>66</u> , to <u>Apr 8</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Apr 7</u> , 19 <u>67</u> , and that death occurred at <u>6:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>L W Malin</u> M.D.		22b. DATE SIGNED <u>Apr 8, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>L W MALIN MD</u>		22d. ADDRESS <u>Brantwood, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>4/12/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>WASHINGTON, D. C.</u>
24. FUNERAL DIRECTOR <u>John T. Rhine</u> ADDRESS <u>3015-12th NE</u>		25a. REC'D BY REG STRAR <u>APR 13 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05621

05621

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1003. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 1 hr.		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Lanham			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George General Hospital				d. STREET ADDRESS 7414 Wilhelm Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Elbert William Grover				4. DATE OF DEATH Month Day Year 4 17 67			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-6-1901	9. AGE (In years last birthday) 66 yrs	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10b. KIND OF BUSINESS OR INDUSTRY MOTION PICTURE, INDY		11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME JOHN GROVER				14. MOTHER'S MAIDEN NAME LILIAN SAUER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO 577 67 4158		17. INFORMANT MRS MARION T. GROVER Address		SAME AS # 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 4200 DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH hours over 1 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes - over 18 yrs.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> . Inspect on <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe M.D.				22. DATE SIGNED 4-18-67			
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.				Address, Street city town & county:			
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE THEREOF APRIL 20, 1967		23c. NAME OF CEMETERY OR REMATORY CEDAR HILL CEM		23d. LOCATION (city or town) (County) (State) SUITLAND, MARYLAND	
24. FUNERAL DIRECTOR W.W. CHAMBERS, CO. RIVERDALE, MARYLAND.				25a. REC'D BY REG STRAR APR 20 1967		25b. REG STRAR'S SIGNATURE J. Charles Judge	



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please, remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

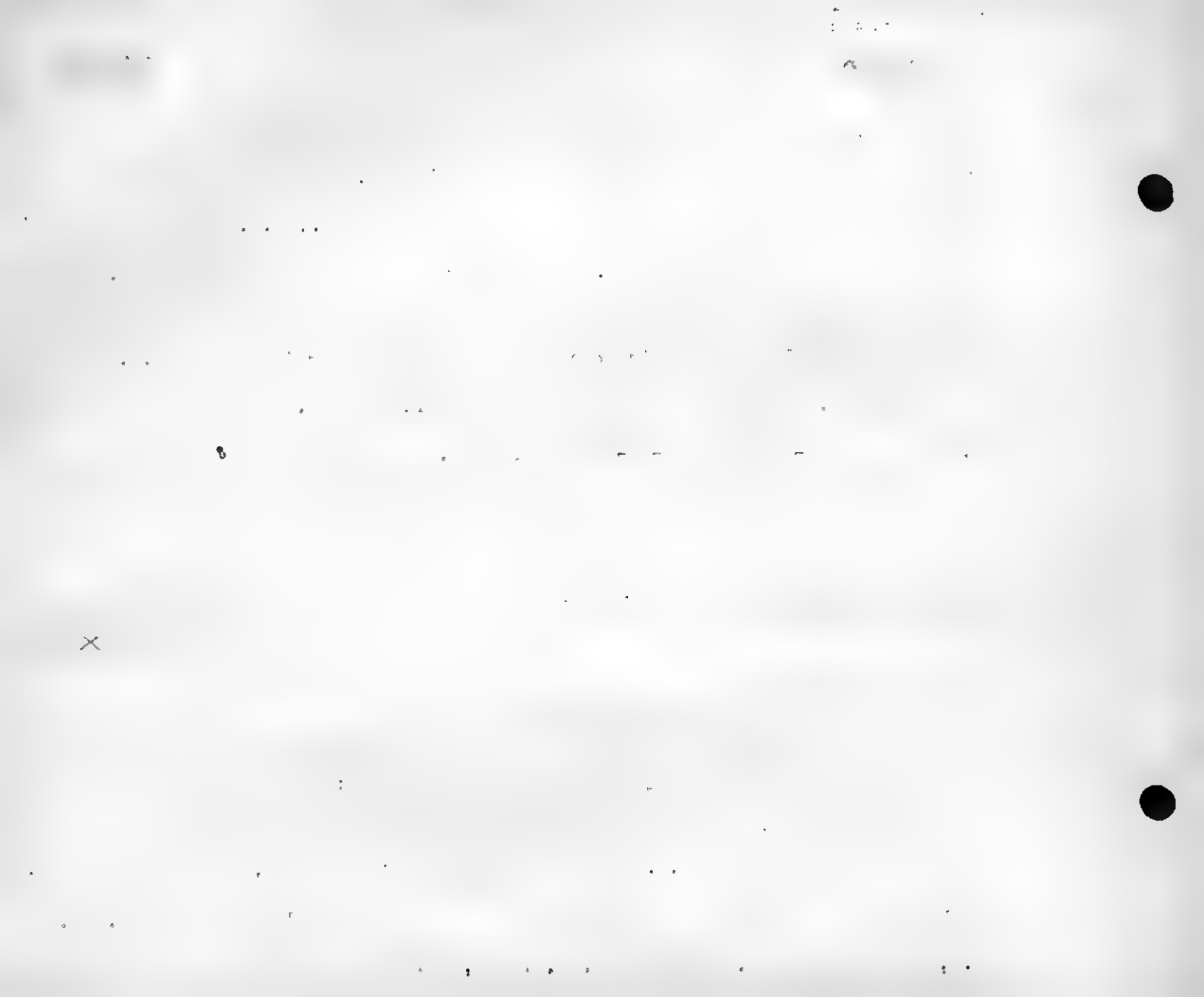
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05622

05622

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 17 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD. b. COUNTY District of Columbia c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, District of Columbia d. STREET ADDRESS 1602 - 61st St., S.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles L. Grubbs		4. DATE OF DEATH Month April Day 12 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/10/17
9. AGE (In years last birthday) 49 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supply Clerk	11. BIRTHPLACE (County & State, or for foreign country) Clark Co. Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Luther L. Grubbs	
14. MOTHER'S MAIDEN NAME Elizabeth E. Tavener		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give year or dates of service) W.W. 2 1942 - 1945	
16. SOCIAL SECURITY NO. 579-09-6989		17. INFORMANT Irene D. Grubbs Same As #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Brochopneumonia - bilateral DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) Pulmonary edema DUE TO (c) Hepatic failure (clinical)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from MARCH 26 19 67 , to April 12, 19 67 , that (I) (we) last saw the deceased alive on April 12, 1967 , and that death occurred at 10:30 AM , from causes and on the date stated above.			
22a. SIGNATURE Mark Pillor, M.D.		22b. DATE SIGNED APR 18 1967	
22c. PHYSICIAN'S NAME (Type) Mark Pillor, M.D.		22d. ADDRESS 7200 Marlboro Pike, District Hts, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4/17/1967	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill	23d. LOCATION (City or Town) (County) (State) Suitland Prince Geo. Md.
24. FUNERAL DIRECTOR W.W. Chambers Co. Inc. 517 11th St. S.E., Wash. D.C.		25a. REC'D BY REGISTRAR APR 18 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05623

05623

FOR STATE
HEALTH DEPT

1 PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Md. b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham		c. LENGTH OF STAY IN IT 64 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Magnolia Gardens Nursing Home		d. STREET ADDRESS 3727 36th St.	
3 NAME OF DECEASED (Type or print) William L. Gscheidle		4 DATE OF DEATH Month 4 Day 27 Year 19 67	
5 SEX M	6 COLOR OR RACE W	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 24 Dec., 1876
9 AGE (in years lost birthday) yrs 90		10 UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - U.S. Govt. Dep. Agriculture		10b. KIND OF BUSINESS OR INDUSTRY Penna.	
11 BIRTHPLACE (State or foreign country) Penna.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME William Gscheidle		14. MOTHER'S MAIDEN NAME Emma Schelle	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 217-52-6049	
17 INFORMANT Mrs. Rose E. Gscheidle		Address (above address)	
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure DUE TO 4200 Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Arteriosclerotic heart disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH minutes Over 10	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Intertrochanteric fracture of left femur			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell in living room of home	
20c. TIME OF INJURY Month, Day, Year Hour 1 PM 16 19 67	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) (County) (State) Same as #2
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe EXAMINER'S NAME (Type) John Kehoe, M.D.,		22. DATE SIGNED 4-28-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/1/67	
23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem.		23d. LOCATION (City or town) (County) (State) Colmar Manor, Md.	
24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.		25a. RECEIVED BY REGISTRAR MAY 2 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

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05624

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #2c & d Film #5-211/57 pc

CERTIFICATE OF DEATH

05624

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 118 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham // Mt. Rainier	
f. STREET ADDRESS 3211 Bunker Hill Rd.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Margaret Hageage		4. DATE OF DEATH Month April Day 17 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 20 July 1887
9. AGE (In years last birthday) 79 Yrs.	10. IF UNDER 1 YEAR Months 79 Days 0 Hours 0 Min. 0	11. BIRTHPLACE (County & State, or foreign country) Lebanon	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Nasaralla Nofil	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO None		17. INFORMANT Mr. Edmond Hageage - St. Takoma Pk. Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease (Son) 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease DUE TO (c) Arteriosclerotic heart disease 4-5-67		INTERVAL BETWEEN ONSET AND DEATH 4-5-67	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19	
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (the hospital) attended the deceased from 19 to April 17, 1967 , that (I) (we) saw the deceased alive on April 17, 1967 , and that death occurred at 9:40A M, from causes and on the date stated above.	
22a. SIGNATURE Leon R. Levitsky, M.D.		22b. DATE SIGNED APR 25 1967	
22c. PHYSICIAN'S NAME (Type) Leon R. Levitsky, M.D.		22d. ADDRESS 3408 Rhode Island Ave. Mt. Rainier, Md.	
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE THEREOF 4/20/67	
23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Com.		23d. LOCATION (City or Town) (County) (State) Colmer Manor, Md.	
24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.		25a. RECEIVED BY REGISTRAR APR 25 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. REGISTRAR'S NAME Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #17 Film 3187 4/12/67 pc
CERTIFICATE OF DEATH

05625

05625

1 PLACE OF DEATH a COUNTY Prince George MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE Maryland b. COUNTY Prince George	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham		c LENGTH OF STAY IN TB	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		d. STREET ADDRESS Box 416	
3 NAME OF DECEASED (Type or print) Henrietta Kerr Hall		4. DATE OF DEATH Month April Day 6 Year 1967	
5 SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 21, 1881
9 AGE (in years, months, days) 85		10. IF UNDER 1 YEAR Months 6 Days 19 Hours 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government	
11. BIRTHPLACE (County & State, or foreign country) Prince George, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Richard Henry Hall		14. MOTHER'S MAIDEN NAME Henrietta Spalding	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO 220 44 8349T	
17. INFORMANT Evelyn Miss Eva Hall		Address Same as #2 (sister)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH CAUSED BY IMMEDIATE CAUSE (a) Pneumonia 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Advanced arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 29, 1967 to April 6, 1967 and that death occurred at 5:30 PM , from causes and on the date stated above.			
22a. SIGNATURE Don B Cameron		22b. DATE SIGNED April 6, 1967	
22c. PHYSICIAN'S NAME (Type) Don B Cameron		22d. ADDRESS Mt. Rainier, Md.	
23a. BURIAL, CREMATION, or other disposal (Specify) Burial		23b. DATE THEREOF 4/8/67	
23c. NAME OF CEMETERY OR CREMATORY Holy Trinity Church		23d. LOCATION (City or Town) (County) (State) Collington P.G. Md.	
24. FUNERAL DIRECTOR Francis Gasch's Sons		ADDRESS Hyattsville, Md.	
25a. REC'D BY REGISTRAR APR 10 1967		25b. REGISTRAR'S SIGNATURE Alanta Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
NO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
2DM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Upper Marlboro c. LENGTH OF STAY IN ID MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) *****					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Upper Marlboro c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Box 3139 Chew, Road d. STREET ADDRESS Box 3139 Chew, Road e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First MADISON Middle William Last Hall			4. DATE OF DEATH Month 4 Day 6 Year 1967		5. SEX M			6. COLOR OR RACE C		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			8. DATE OF BIRTH 2-14-1895		9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME William Hall					14. MOTHER'S MAIDEN NAME Mary Forbes					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. 215-12-1447		17. INFORMANT William Washington			Address 8608 Willow Ave, Upper Marlboro Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastric hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Carcinoma of stomach DUE TO (b) Carcinoma of stomach DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH Days Months		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 7/28, 1965 to 4/6, 1967 , that (I) (we) last saw the deceased alive on 4/6, 1967 , and that death occurred at 11 PM , from the causes and on the date stated above.										
22a. SIGNATURE Thomas L. Fieldson					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) THOMAS L. Fieldson M.D.					22d. ADDRESS BYANDYWINE, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 4/10/67		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City, town or county) (State) Washington, D.C.			
24. FUNERAL DIRECTOR McGuire Funeral Service					ADDRESS 1820 9th St., N.W.		25a. REC'D BY REGISTRAR APR 10 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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CERTIFICATE OF DEATH

05627

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 2 hours after death.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE MARYLAND b. COUNTY P. Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLINTON		c. LENGTH OF STAY IN 1b 23 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) PINEVIEW GARDENS HEALTH CARE CENTER		d. STREET ADDRESS 5916 Muir Drive	
3. NAME OF DECEASED (Type or print) First OCTAVIA Middle S. Last HALL		4. DATE OF DEATH Month April Day 29 Year 1967	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-26-70
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 96 yrs.
13. FATHER'S NAME CHARLES SNEAD		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 228-70-6516 J	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last Arteriosclerotic & Hypertensive Cardiovascular Disease 4F DUE TO 5-10 years			INTERVAL BETWEEN ONSET AND DEATH 4-5 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan. 30, 1967 , to April 29, 1967 , that (I) (we) last saw the deceased alive on April 29, 1967 , and that death occurred at 9:25 PM , from causes and on the date stated above.			
22a. SIGNATURE Walcott W. Gibson M.D.		22b. DATE SIGNED April 29, 1967	
22c. PHYSICIAN'S NAME (Type) Walcott W. GIBSON, M.D.		22d. ADDRESS 4300 50th, Bayhills Road, Marlow Heights, Md. 20031	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/2/67	23c. NAME OF CEMETERY OR CREMATORY Bland Cemetery	23d. LOCATION (City or Town) (County) (State) Bland Virginia
24. FUNERAL DIRECTOR J. Wm. Lee & Sons		25a. REC'D BY REGISTRAR Wash, D. C.	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE MAY 2 1967	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05628

05628

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3, Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN TB DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillside			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				d. STREET ADDRESS 1114 52nd Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Edward Last Hamilton				4. DATE OF DEATH Month 4 Day 20 Year 19 67			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-16-35		9. AGE (In years, last birthday) yrs 31		10. IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gas Station		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ma		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Robert E. Hamilton				14. MOTHER'S MAIDEN NAME Alice Akers			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes		16. SOCIAL SECURITY NO 217-36.6946		17. INFORMANT Mabel E Hamilton		Address same 2.D	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema DUE TO (b) Status epilepticus DUE TO (c) Cerebral dural adhesion (right temporal lobe)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , inspection <input checked="" type="checkbox"/> , inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>[Signature]</i> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John Kehoe M.D., Riverdale, Maryland				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4.25.67		23c. NAME OF CEMETERY OR CREMATORY Alexandria, National		23d. LOCATION (City or town) (County) (State) Alexandria, Virginia	
24. FUNERAL DIRECTOR Lee Funeral Home 300.4th st N E				25a. REC'D BY REG. STRAR APR 27 1967		25b. REG. STRAR'S SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #2d & 16 File #3385/12/67 pc

05629

CERTIFICATE OF DEATH

05629

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 1 Hour.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edmonston	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital			d. STREET ADDRESS 5103 5001 Crittenden St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3 NAME OF DECEASED (Type or print) First Charles Middle Francis Last Hammett			4 DATE OF DEATH Month April Day 29 Year 67		
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 2, 1898		9 AGE (in years last birthday) yrs. 68
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government		11. BIRTHPLACE (County & State, or foreign country) Pennsylvania	
13. FATHER'S NAME Allen Hammett			14. MOTHER'S MAIDEN NAME Jennie Hartley		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give year or dates of service) Army WWI		16. SOCIAL SECURITY NO. 215 26 0443		17. INFORMANT Address Mrs. Bertha V. Hammett Same as #2 (wife)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) (c)					INTERVAL BETWEEN ONSET AND DEATH 2 hrs.
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (1) (this hospital) attended the deceased from 8/3, 1958 to 4/29, 1967 , that (1) (we) lost the deceased alive on 4/24, 1967 , and that death occurred at 11:30 A.M. from causes and on the date stated above.					
22a. SIGNATURE F. E. Musser M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4/29/67	
22c. PHYSICIAN'S NAME (Type) F. E. Musser		22d. ADDRESS 4410 74th Ave Hyattsville, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/2/67	23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City or Town) (County) (State) Baltimore Baltimore Md.	
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.			25a. REC'D BY REGISTRAR MAY 2 1967		25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if any, within 72 hours after death.

VR A15 (4)
20 M 1/66

05631

Item #9 Film #G388 1/25/67 pc

CERTIFICATE OF DEATH

05631

1 PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 13 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bladensburg d. STREET ADDRESS 4110 - 46th Place e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3 NAME OF DECEASED (Type or print) Helen First - Middle Harris Last			4 DATE OF DEATH April 14 19 67 Month Day Year				
5 SEX Female	6 COLOR OR RACE Colored	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/17/1988		9 AGE (In years last birthday) 78 1/2 yrs		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (County & State, or foreign country) Bladensburg Md			
13 FATHER'S NAME Charles Chase			14 MOTHER'S MAIDEN NAME Josephine Barket				
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO None		17 INFORMANT Charles Harris - 1218 Queen St NE Address			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebrovascular Accident - Thrombosis DUE TO (b) Arteriosclerosis DUE TO (c) Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					INTERVAL BETWEEN ONSET AND DEATH		
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pneumonia							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that the (this hospital) attended the deceased from April 1, 1967 , to April 14, 1967 , that we (we) last saw the deceased alive on April 14, 1967 , and that death occurred at 1:15 AM , from causes and on the date stated above.							
22a. SIGNATURE Edwin J. Jensen M.D.			22b. DATE SIGNED April 14, 1967		22c. PHYSICIAN'S NAME (Type) Edwin J. Jensen, M.D.		
22d. ADDRESS Prince Georges General Hospital			22e. REC'D BY REGISTRAR Charles Judge				
23a. BURIAL, CREMATION, REMOVAL (Specify) 4-18-67		23b. DATE THEREOF 4-18-67		23c. NAME OF CEMETERY OR CREMATORY Charles			
23d. LOCATION (City or Town) (County) (State) Bladensburg Md		23e. REGISTRAR'S SIGNATURE Charles Judge					

05632

CERTIFICATE OF DEATH

05632

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reassemble carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 12 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chapel Oaks			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS 5345 Addison Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Louis -- Harris		4. DATE OF DEATH Month Day Year April 5, 1967	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 23, 1918
9. AGE (In years last birthday) 48 yrs.		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Labor	
11. BIRTHPLACE (County & State, or foreign country) Way County N.C.		12. CITIZEN OF WHAT COUNTRY? US.	
13. FATHER'S NAME William Ollie Harris		14. MOTHER'S MAIDEN NAME Mrs. Bessie Williams	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Blannie M. Harris		Address 5345 Addison Rd. Chapel Oaks	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> 5400 DUE TO (b) <u>Massive upper GI. bleeding</u> DUE TO (c) <u>Shen gastric ulcer</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>March 24, 1967</u> to <u>April 5, 1967</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>April 5, 1967</u> , and that death occurred at <u>2:30 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>D.S. Banisadr</u>		22b. DATE SIGNED April 5, 1967	
22c. PHYSICIAN'S NAME (Type) Amir Banisadr, P.D.		22d. ADDRESS 6323 Landover Rd., Cheverly, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 4-10-67	23c. NAME OF CEMETERY OR CREMATORY Church Cemetery	23d. LOCATION (City or Town) (County) (State) Ra leigh, N.C.
24. FUNERAL DIRECTOR <u>John T. Rhee</u>		25a. REC'D BY REGISTRAR APR 13 1967	
ADDRESS 3015 12th St. N.E. D.C.		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

CERTIFICATE OF DEATH

05633

05633

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Reside in institution) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 55 days	d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairmont Heights
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS 5905 Lee Place	
3. NAME OF DECEASED (Type or print) First Charles Middle D. Last Harrison		4. DATE OF DEATH Month April Day 21 Year 1967	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/27/98
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Bakers Helper	
11. BIRTHPLACE (County & State, or foreign country) Prince George's Co Md		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Francis Harrison		14. MOTHER'S MAIDEN NAME Annie Stephenson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Frances Harrison		Address Same as 2 D	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic failure DUE TO (b) Carcinoma of lungs DUE TO (c) Pneumonia		INTERVAL BETWEEN ONSET AND DEATH Aug. 1966 Apr. 1967	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Benign prostatic hypertrophy & cystitis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan , 1967, to Apr. 21 , 1967, that (I) (we) last saw the deceased alive on 21 Apr , 1967, and that death occurred at 8:25 M. from causes on and on the date stated above.			
22a. SIGNATURE Ronald P. Hairston		22b. DATE SIGNED 22 Apr 67	
22c. PHYSICIAN'S NAME (Type) Ronald P. Hairston, M. D.		22d. ADDRESS 3302 Hayes St. Glenarden Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) 4-26-67		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY Mt Olivet		23d. LOCATION (City or Town) (County) (State) Wash N.E	
24. FUNERAL DIRECTOR H.S. Washington & Sons		25a. RECORD BY REGISTRAR APR 27 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05634

05634

1 PLACE OF DEATH a. COUNTY PG. Riverdale, MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MD PG. b. COUNTY PG.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale,		c. LENGTH OF STAY IN 1b 16 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bladensburg,			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Leland Memorial Hospital				d. STREET ADDRESS 5217 Newton Street,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last Wilma Ethel Harvey				4 DATE OF DEATH Month Day Year April 17 19 67			
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Jan- 18, 1914	9 AGE (In years last b. 53 yrs)	10 IF UNDER 1 YEAR Months Days Hours Min.		11 IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife.		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11 BIRTHPLACE (County & State, or foreign country) N-Carolina		12 CITIZEN OF WHAT COUNTRY? Amer	
13. FATHER'S NAME XX James M. Hicks				14. MOTHER'S MAIDEN NAME XX Bessie Deathridge			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Eugene Leland Hospital, 4408 Queensbury Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) VENTRICULAR FIBRILLATION DUE TO (b) ACUTE MYOCARDIAL INFARCTION DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.				INTERVAL BETWEEN ONSET AND DEATH 15 MIN 15 DAYS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4-2, 1967, to 4-17, 1967, that (I) (we) last saw the deceased alive on 4-17, 1967, and that death occurred at 7:30 p.m. from causes and on the date stated above.							
22a. SIGNATURE C. J. Houmann				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4-17-67	
22c. PHYSICIAN'S NAME (Type) C. J. HOUMANN				22d. ADDRESS RIVERDALE MD.			
23a. BURIAL, CREMATION, or other disposal (Specify) Burial		23b. DATE THEREOF 4/21/67		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d. LOCATION (City or Town) (County) (State) Colmar Manor P.G. Md.	
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Maryland				25a. REC'D BY REGISTRAR APR 24 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05635

05635

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed with in 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE District Of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital		e. STREET ADDRESS 1336 Ridge Place, S.E.	
3 NAME OF DECEASED (Type or print) Walter Nelson Hicks, Jr.		4 DATE OF DEATH Month 4 Day 26 Year 1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH 5-22-1942
9 AGE (in years last birthday) 24 yrs		10 IF UNDER 1 YEAR Months 4 Days 26 Hours 19 Min 67	11 CITIZEN OF WHAT COUNTRY? USA
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY U. S. Govt.	
11 BIRTHPLACE (State or foreign country) Washington, D. C.		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Walter N. Hicks, Sr.		14 MOTHER'S MAIDEN NAME Miriam Nunemaker	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 577-58-3021	
17 INFORMANT Elizabeth Childs-Aunt		Address Same As #2	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Laceration of brain 8254 DUE TO Skull fracture Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Driver of car involved in collision.	
20c. TIME OF INJURY Month, Day, Year 10:30pm 4-26-1967		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) US Rt. 1, 1 1/2 mile so. of Annapendale Rd.		20f. Beltsville, Md. (State)	
21 I certify that I took charge of the remains described above held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe, M.D.		22. DATE SIGNED 4-27-67	
EXAMINER'S NAME (Type) John Kehoe, M.D.		Address (Street, city, town, or county) Riverdale, Md.	
23a. BURIAL OR CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 5/1/67	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Suitland Maryland	
24 FUNERAL DIRECTOR J. Wm. Lees Sons		25a. REC'D BY REGISTRAR MAY 1 1967	
Address Washington, D. C.		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05636

05636

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) W. Hyattsville		c. LENGTH OF STAY IN TB 21 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2000 Ravenswood Street		e. STREET ADDRESS 2000 Ravenswood St.	
3. NAME OF DECEASED (Type or print) First JOSEPH Middle FRANCIS Last HOGAN, SR.		4. DATE OF DEATH Month 4 Day 5 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-29-1904
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ACCOUNTANT		9b. AGE (In years last birthday) 62 yrs.	
10b. KIND OF BUSINESS OR INDUSTRY U.S. Government		11. BIRTHPLACE (State or foreign country) Torrington, Conn.	
13. FATHER'S NAME PATRICK HOGAN		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO 041-10-1855	
17. INFORMANT Dorothy K. Hogan		Address 2000 Ravenswood St	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal Insufficiency 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of Prostate DUE TO Melanoma (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 48 hrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June 1966 to April 1967 , that (I) met last saw the deceased alive on Apr. 5 19 67 , and that death occurred at 125 P. M. from the causes and on the date stated above			
22a. SIGNATURE Bernard A. Fitzgerald		22b. DATE SIGNED 4-5-67	
22c. PHYSICIAN'S NAME (Type) BERNARD A. FITZGERALD		22d. ADDRESS 217 Univ. Blvd E, SIL. SP. Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4/10/67	23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven	23d. LOCATION (City, town, or county) (State) Silver Spring, Montgomery Md.
24. FUNERAL DIRECTOR'S SIGNATURE S. Gasch's Sons		25a. REC'D BY REGISTRAR Charles Judge	
ADDRESS Hyattsville, Md		25b. REGISTRAR'S SIGNATURE Charles Judge	
DATE APR 10 1967			

MEDICAL CERTIFICATION

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05637

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05637

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brentwood		c. LENGTH OF STAY IN 1b hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brentwood		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) B&O Railroad, 225 ft. south of mile post 3410				d. STREET ADDRESS 3714 Shepherd Street.			
3 NAME OF DECEASED (Type or print) William Curtis Howard				4 DATE OF DEATH Month 4 Day 22 Year 19 67			
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 10 May 1925		9 AGE (In years last birthday) yrs 41	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) Wash., D.C.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wollman Howard				14. MOTHER'S MAIDEN NAME Mildred Lopper			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or Unknown) No		16. SOCIAL SECURITY NO 578-22-5231		17. INFORMANT Mr. Wollman Howard - Dr., College Pk. Address 7323-Radcliffe			
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Evisceration DUE TO From trauma - struck by railroad train. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ (c) _____				INTERVAL BETWEEN ONSET AND DEATH			
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)				9. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Struck by railroad train.					
20c. TIME OF INJURY Month Day Year Hour a.m. 10:30am 4-22-19 67		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home farm factory street office bldg. etc.) B&O Railroad, 225 ft. south of mile post 3410		20f. (City or town) (County) (State) Brentwood, Md.	
21 I certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe, M.D.		22. DATE SIGNED 4-24-67		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street city town or county)			
23a. BURIAL CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 4/25/67		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem.		23d. LOCATION City or Town (County) (State) Colmar Manor, Md.	
24. FUNERAL DIRECTOR Home Inc.		ADDRESS Nailey's Funeral Maryland		25a. REC'D BY REGISTRAR APR 26 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05638

05638

1 PLACE OF DEATH a COUNTY Prince George's MARYLAND				2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 5 hours			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's Hospital				d. STREET ADDRESS 4550 Ammandale Road			
3 NAME OF DECEASED (Type or print) Randy Gene Ingram				4 DATE OF DEATH Month April Day 27 Year 1967			
5 SEX male		6 COLOR OR RACE white		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH Feb. 26, 1965	
9 AGE (in years lost birthday) yrs 2		10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) N/A		10b. KIND OF BUSINESS OR INDUSTRY —		11 BIRTHPLACE (State or foreign country) Takoma Park, Md.	
12 CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME HOMER W. INGRAM			
14. MOTHER'S MAIDEN NAME Betty Jean Linger				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No			
16. SOCIAL SECURITY NO N/A				17. INFORMANT Mr. Homer W. Ingram, Same as			
18 CAUSE OF DEATH (Enter on any cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocarditis DUE TO (c) —							INTERVAL BETWEEN ONSET AND DEATH minutes days
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):							9. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (county) (State)	
21 I certify that I took charge of the remains described above held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John Kehoe, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Riverdale, Md.			
22. DATE SIGNED 2-29-67							
23a. BURIAL CREMATION PROVAL (Specify)		23b. DATE THEREOF APR 30, 1967		23c. NAME OF CEMETERY OR CREMATORY Bell Valley Cem		23d. LOCATION (City or town) (county) (State) CRAIGSVILLE, VA	
24. FUNERAL DIRECTOR Harold S. Wade, Laurel, Md.		25. REL. BY REG. STRIP MAY 1 1967		26. SIGNED BY REG. STRIP John Charles Judge		27. SIGNED BY REG. STRIP John Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05639

CERTIFICATE OF DEATH

05639

1 PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale,		c LENGTH OF STAY IN lb 13 days	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Leland Memorial Hospital		d STREET ADDRESS 7440 Dangerfield Road	
3 NAME OF DECEASED (Type or print) Luther A. Irby		4. DATE OF DEATH Month 4 Day 22 Year 19 67	
5. SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-6-11
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Transfer Clerk		10b KIND OF BUSINESS OR INDUSTRY Andrews Air	11. BIRTHPLACE (County & State, or foreign country) Virginia
13 FATHER'S NAME Luther Henry Irby		14 MOTHER'S MAIDEN NAME Rosa Switzerlet	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO	
17 INFORMANT Admitting Record		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> 332X DUE TO (b) <u>General arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office b-dg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Apr 9</u> , 19 <u>67</u> , to <u>Apr 24</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Apr 21</u> , 19 <u>67</u> , and that death occurred at <u>7:45</u> M, from causes and on the date stated above			
22a SIGNATURE <u>LWM</u>		22b DATE SIGNED 4-22-67	
22c PHYSICIAN'S NAME (Type) <u>LWM M.D.</u>		22d ADDRESS <u>Riverdale, MD.</u>	
23a BURIAL, CREMATION, OR REMOVAL (Specify) <u>BURIAL</u>	23b DATE THEREOF 4-24-67	23c NAME OF CEMETERY OR CREMATORY <u>TRINITY MEMORIAL</u>	23d LOCATION (City or town) (County) (State) <u>WALDORF CHARLES, MD.</u>
24 FUNERAL DIRECTOR <u>The HUNT FUNERAL HOME, WALDORF, MD.</u>		25a REC'D BY REG. STRAR <u>APR 26 1967</u>	
		25b REG. STRAR'S SIGNATURE <u>J. Charles Judge</u>	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 of the funeral director Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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VR A15ME (5)
6M 1/67

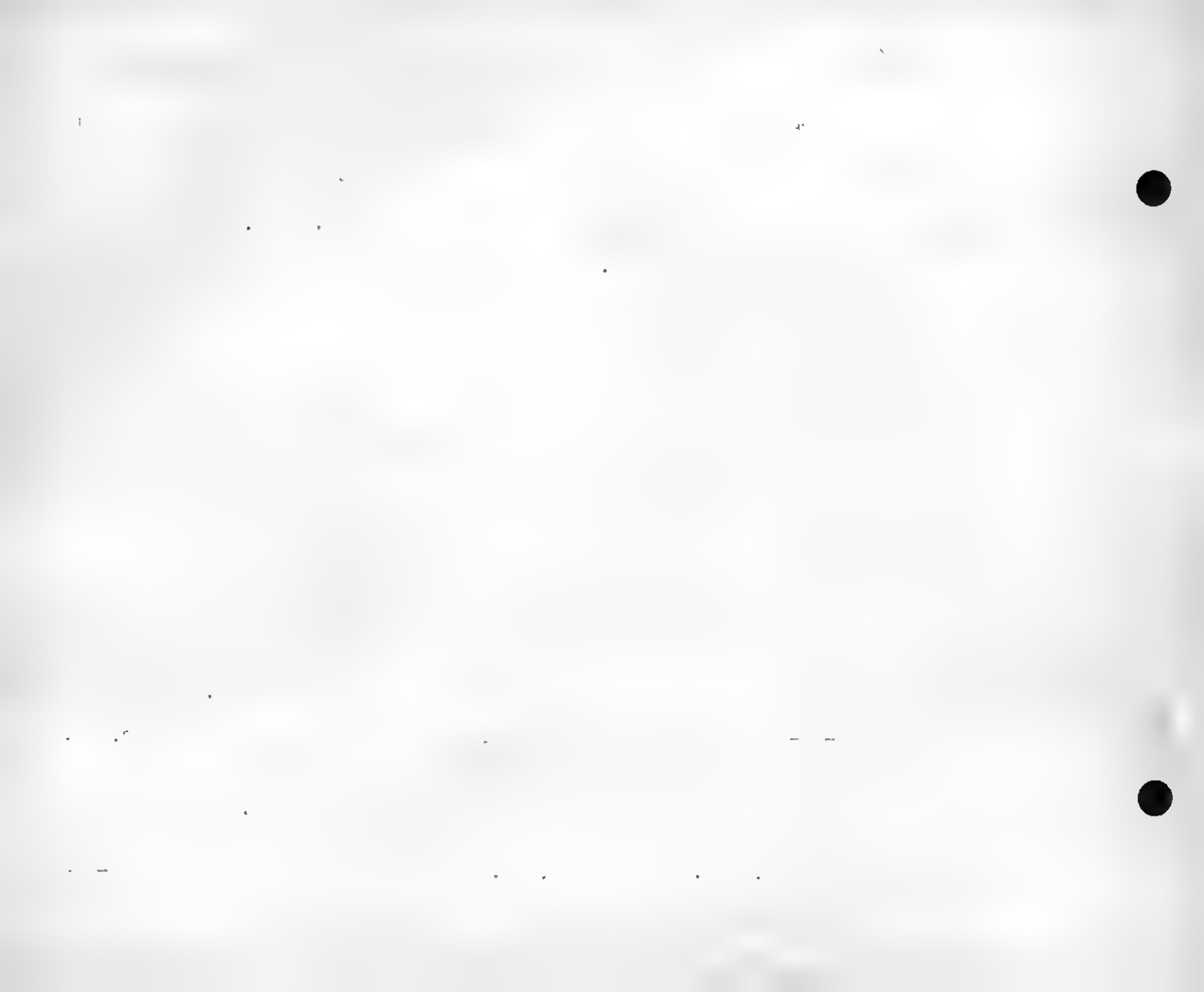
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05640

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05640

1 PLACE OF DEATH a COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a STATE Maryland b COUNTY Prince George's	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c LENGTH OF STAY in lb DOA	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		d STREET ADDRESS Hyattsville	
3 NAME OF DECEASED (Type or print) Arthur F. Jefferson		4 DATE OF DEATH 4-18-67	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 4-21-1934
9 AGE (In years, last birthday) 32 yrs		10 UNDER 1 YEAR 18 Months 19 Days 67 Hours 19 Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Driver		10b KIND OF BUSINESS OR INDUSTRY —	
11 BIRTHPLACE (State or foreign country) Virginia		12 CITIZEN OF WHAT COUNTRY U.S.A.	
13 FATHER'S NAME Arthur F. Jefferson Sr.		14 MOTHER'S MAIDEN NAME Ruth	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) —		16 SOCIAL SECURITY NO —	
17 INFORMANT Ruth Phillips (Mother)		Address 113 Belknap Rd Hyattsville, Md	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia DUE TO Strangulation by hanging Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) — (c) —		INTERVAL BETWEEN ONSET AND DEATH —	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —			
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH Hung self with shirt tied to top of door.		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) about 3:30am 4-18-67	
20c TIME OF INJURY Month Day, Year 4-18-67		20d PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) Cell, Hyattsville Jail, Hyattsville, Md.	
21 I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED 4-18-67	
ACTUAL SIGNATURE John Kenoe		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John Kenoe, M.D. Riverdale, Md.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF April 22-1967	
23c NAME OF CEMETERY OR CREMATORY St. Lincoln		23d LOCATION (City or Town) Belknap Rd L. Kenoe Md	
24 FUNERAL DIRECTOR Arthur Travers		25a REC'D BY REGISTRAR Charles Judge	
25b ADDRESS 254 Carroll St		25c DATE APR 21 1967	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05641

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05641

1 PLACE OF DEATH a COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b COUNTY Prince George's	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Riverdale		c LENGTH OF STAY IN 1b DOA	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital		e STREET ADDRESS 11342 Cherry Hill Road	
3 NAME OF DECEASED (Type or print) Magdalena Jimenez		4 DATE OF DEATH Month 4 Day 9 Year 19 67	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8 DATE OF BIRTH 17 July 1892
9 AGE (In years lost birthday) 74 yrs		10 IF UNDER 1 YEAR Months 4 Days 9 Hours 67 Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) Cuba		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Unknown		14 MOTHER'S MAIDEN NAME Unknown	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO	
17 INFORMANT Pedro DeArmas		Beltsville, Md. 11342 Cherry Hill Road	
8 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure DUE TO Hypertensive arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) (c)		INTERVAL BETWEEN ONSET AND DEATH minutes over 15 yrs.	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c TIME OF INJURY Month, Day, Year Hour 0 m 19 p.m.	20d INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home form, factory, street, office bldg, etc.)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe EXAMINER'S NAME (Type) John Kehoe, M.D.		22. DATE SIGNED 4-10-67	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 4/12/1967	
23c NAME OF CEMETERY OR CREMATORY Mt. Olivet		23d LOCATION (City, town) (County) (State) Washington, D.C.	
24 FUNERAL DIRECTOR W. Ernest Jarvis Co., Inc.		25a RECD BY REGISTRAR 1132 You Street, N.W.	
25b REGISTRAR'S SIGNATURE gcharles Judge		25c RECD BY REGISTRAR APR 13 1967	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If body delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1 67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05642

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05642

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, f institution Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham		c. LENGTH OF STAY IN TB 2 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 9309 Rollingview Drive		d. STREET ADDRESS 9309 Rollingview Drive	
3 NAME OF DECEASED (Type or print) Alta Mae Johnson		4 DATE OF DEATH Month 4 Day 25 Year 19 67	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 25 May 1908
9 AGE (In years lost birthday) 58 yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	
10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) IOWA	
13 FATHER'S NAME WILLIAM HASTIE		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
14 MOTHER'S MAIDEN NAME UNKNOWNED		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) (If yes give war or dates of service) NO	
16 SOCIAL SECURITY NO. NONE		17 INFORMANT JERRY W. JOHNSON Address 10102 52ND AVE. COLLEGE PARK, MD.	
18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory failure 41X DUE TO Bronchial asthma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH days over 10 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , inspection <input checked="" type="checkbox"/> , inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe M.D.		22 DATE SIGNED 4-26-67	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street city town or county)	
23a. BURIAL CREMATION, REMOVAL, (Specify)	23b. DATE THEREOF 4-28-67	23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEM	23d. LOCATION (City or Town) (County) (State) BLADENSBURG MD
24. FUNERAL DIRECTOR W.W. Chambers Co. RIVERDALE, MD.		25a. REC'D BY REG. STAFF DATE APR 28 1967	
		25b. REG. STAFF'S SIGNATURE John Charles Judge	

05643

CERTIFICATE OF DEATH

05643

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE c. LENGTH OF STAY IN 1b 2 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) USAF HOSPITAL ANDREWS		2. USUAL RESIDENCE (Where deceased lived, if institution a Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE'S c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYATTSVILLE MARYLAND d. STREET ADDRESS 4708 COOPER LANE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MOLLY GARFIELD JONES		4. DATE OF DEATH Month APRIL Day 18 Year 19 67	
5. SEX FEMALE	6. COLOR OR RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9 APRIL 1882
9. AGE (In years last birthday) yrs 85		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) NEWCASTLE VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM B DOSS		14. MOTHER'S MAIDEN NAME ELIZA HUFFMAN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Darline FUCHANAN DAUGHTER-IN-LAW		Address 4708 COOPER LANE HYATTSVILLE MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) MYOCARDIAL INFARCTION DUE TO (c) CORONARY ARTERIOSCLEROSIS INTERVAL BETWEEN ONSET AND DEATH 50 MIN 2 DAYS YEARS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 16 APRIL, 1967 , to 18 APRIL, 1967 , that (I) (we) last saw the deceased alive on 18 APRIL 19 67 , and that death occurred at 7:51 PM , from causes and on the date stated above.			
22a. SIGNATURE Stephen Podolsky M.D.		22b. DATE SIGNED 18 APRIL 1967	
22c. PHYSICIAN'S NAME (Type) STEPHEN PODOLSKY, CAPT, USAF, MC		22d. ADDRESS USAF HOSPITAL ANDREWS ANDREWS AFB, WASHINGTON DC 20331	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE THEREOF 4/19/67	23c. NAME OF CEMETERY OR CREMATORY Sherwood Cemetery	23d. LOCATION (City or Town) (County) (State) Roanoke, Virginia
24. FUNERAL DIRECTOR The S. H. Hines Co. Washington D. C.		25a. REC'D BY REGISTRAR APR 20 1967 25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05644

05644

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Hyattsville (Cheverly)		c. LENGTH OF STAY IN 1b 33 hours		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Hyattsville		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's Hospital				d. STREET ADDRESS 7348 Landover Rd. Apt. E			
3. NAME OF DECEASED (Type or print) First Middle Last Clinton Ray Jordan				4. DATE OF DEATH Month Day Year April 30 19 67			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1 February 1965		9. AGE (In years lost birthday) yrs 2	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Kansas		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert R. Jordan				14. MOTHER'S MAIDEN NAME Renee Dousset			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO -		17. INFORMANT Address Mr. Robert R. Jordan (above address)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Decerebrate rigidity (Father) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Brain stem injury DUE TO (c) Trauma-fall from apartment balcony						INTERVAL BETWEEN DEATH AND DEATH 33 hours 33 hours 33 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Fell from third story balcony of apartment building.					
20c. TIME OF DEATH Month Day Year 5:30 PM 4-28-67 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, etc.) same as 2 Home		20f. (City or town) (County) (State) Riverdale, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe, M.D.				22. DATE SIGNED 4-30-67			
23a. BURIAL CREMATION REMOVAL Burial		23b. DATE THEREOF 5/4/67		23c. NAME OF CEMETERY OR CREMATORY Nelson Cemetery		23d. LOCATION (City or town, County, State) Nelson, Nebraska	
24. FUNERAL DIRECTOR Valley's Funeral Home Inc.				ADDRESS Mt. Rainier Maryland		25a. REC'D BY REGISTRAR MAY 3 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge			

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05645

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05645

1 PLACE OF DEATH a COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a STATE Maryland b COUNTY Pro Georges	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c LENGTH OF STAY IN 1b D O A	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d STREET ADDRESS Route 94	
3 NAME OF DECEASED (Type or print) First Susan Middle Priscilla Last Kachelries		4 DATE OF DEATH Month April Day 6 Year 67	
5 SEX female	6 COLOR OR RACE white	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH March 16, 1887
9 AGE (In years last birthday) yrs 80		10 UNDER 1 YEAR Months 19 Days 19 Hours 19 Min 19	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b KIND OF BUSINESS OR INDUSTRY own home	
11 BIRTHPLACE (State or foreign country) Pennsylvania		12 CITIZEN OF WHAT COUNTRY? U S A	
13 FATHER'S NAME Dolan Smith		14 MOTHER'S MAIDEN NAME Hulga Levan	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16 SOCIAL SECURITY NO 187 03 0292	
17 INFORMANT W. Jean Kachelries		Address Woodbine, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary Edema 445X DUE TO (b) Congestive Heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) Hyper tension C V Disease years		INTERVAL BETWEEN ONSET AND DEATH	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> no CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I, or Part I of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Dayton Watkins		22. DATE SIGNED 4-7-67	
EXAMINER'S NAME (Type) DAYTON WATKINS		Address (Street, city, town, or county) Md.	
23a BURIAL CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF April 8, 1967	23c NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery	23d LOCATION (City or town) (County) (State) Colmar Manor Pro Geo Md.
24 FUNERAL DIRECTOR F. Gasch's Sons		ADDRESS Hyattsville, Md.	
25a REC'D BY REGISTRAR APR 10 1967		25b REGISTRAR'S SIGNATURE Charles Judge	

05646

CERTIFICATE OF DEATH

05646

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Res dence before admision) a. STATE <u>DC</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LANHAM, MD</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wash DC</u>	
c. LENGTH OF STAY IN lb. <u>6 months</u>		d. STREET ADDRESS <u>1604 Q St NW</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wagnolia Gardens Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>EMMA E KAISER</u>		4. DATE OF DEATH Month Day Year <u>APRIL 14, 19 67</u>	
5 SEX <u>FEMALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. AGE (In years last birthday) <u>Aug. 21, 1889</u> 77 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HW</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Wash DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOHN KAISER</u>		14. MOTHER'S MAIDEN NAME <u>Josephine Geier</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>JNK</u>	
17. INFORMANT <u>MR Myer</u>		Address <u>2659 Conn Ave NW</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>32X</u> <u>Branchiopneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>CVA (Cerebral Thrombosis)</u> (c) <u>Generalized arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>9 days</u> <u>1 week</u> <u>10 years</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Dec, 1966</u> , to <u>Apr. 1967</u> , that (I) (we) last saw the deceased alive on <u>APRIL 14, 1967</u> , and that death occurred at <u>4:33 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Thomas G. Maloney</u>		22b. DATE SIGNED <u>4/14/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Thomas G. Maloney</u>		22d. ADDRESS <u>4714 71st Ave Woodlawn, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4/17/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST MARY'S</u>	23d. LOCATION (City or Town) (County) (State) <u>WASH DC</u>
24. FUNERAL DIRECTOR <u>Shirley Funeral Home</u>		25a. REC'D BY REGISTRAR DATE <u>APR 17 1967</u>	
ADDRESS <u>3605 18th St NW</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

CERTIFICATE OF DEATH

05647

05647

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE c. LENGTH OF STAY IN 1b 4 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) US AIR FORCE HOSPITAL ANDREWS		2. USUAL RESIDENCE (Where deceased lived, if institut on: Residence before admision) a. STATE VIRGINIA b. COUNTY FAIRFAX c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FAIRFAX d. STREET ADDRESS 3708 Morningside Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ROBERT (NMN) KAUCH		4. DATE OF DEATH Month Day Year APRIL 7 19 67	
5. SEX MALE	6. COLOR OR RACE CAU	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 14 July 1894
9. AGE (In years last birthday) 72 yrs		10. IF UNDER 1 YEAR Months Days Hours Min. 72	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) US AIR FORCE		10b. KIND OF BUSINESS OR INDUSTRY US AIR FORCE	
11. BIRTHPLACE (County & State or foreign country) PHILADELPHIA, PENNA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN KAUCH		14. MOTHER'S MAIDEN NAME ELLA REINER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES 80 June 1948		16. SOCIAL SECURITY NO. 231-58-4375	
17. INFORMANT WIFE		Address SAME AS #2	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) MYOCARDIAL INFARCTION DUE TO (c) ARTERIOSCLEROSIS OF CORONARY ARTERIE		INTERVAL BETWEEN ONSET AND DEATH 1/2 hour 6 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from 4 April, 19 67 to 7 April, 1967 , that (X) (we) last saw the deceased alive on 7 April, 19 67 , and that death occurred at 2:45 PM , from causes and on the date stated above.			
22a. SIGNATURE <i>Charles D. Phelps</i>		22b. DATE SIGNED 7 April 67	
22c. PHYSICIAN'S NAME (Type) CHARLES D. PHELPS, CAPT USAF MC		22d. ADDRESS USAF Hosp Andrews Andrews AFB, Wash DC 20331	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11 Apr 1967	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR <i>David V. Crandall</i> Everly Funeral Home		25a. REC'D BY REGISTRAR DATE 10 1967	
25b. REGISTRAR'S SIGNATURE <i>James J. ...</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #9 Film #33 P. 1/26/67

CERTIFICATE OF DEATH

05648

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Prince Georges		MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE District of Columbia		b. COUNTY n/a	
b. CITY OR TOWN (If out of corporate limits write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 30 minutes		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 4498 McArthur Blvd. N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First John Middle G. Last Kerrigan				4 DATE OF DEATH Month April Day 13 Year 19 67			
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 5/30/86		9 AGE (n years last birthday) 81 80yrs		10 UNDER 24 HRS Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired (War Dept.)		10b. KIND OF BUSINESS OR INDUSTRY GOVT.		11 BIRTHPLACE (County & State, or foreign country) Providence R.I.		12 CITIZEN OF WHAT COUNTRY? U.S.	
13 FATHER'S NAME John Edward Kerrigan				14. MOTHER'S MAIDEN NAME UNKNOWN			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO		17. INFORMANT Address			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Infarction, Right temporal lobe DUE TO (b) Cerebral Arteriosclerosis DUE TO (c) Cerebral Arteriosclerosis Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from April 12, 1967 , to April 13, 1967 , that (I) (we) lost saw the deceased alive on April 13, 1967 , and that death occurred at 12:45 PM , from causes on and on the date stated above.							
22a. SIGNATURE Oliver B. Bond				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIR. <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED April 13, 1967	
22c. PHYSICIAN'S NAME (Type) Oliver B. Bond, M.D.				22d. ADDRESS 6872 Riverdale Rd. Lanham, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/15/67		23c. NAME OF CEMETERY OR CREMATORY 1st St. Baptist		23d. LOCATION (City or Town) (County) (State) Washington D.C.	
24. FUNERAL DIRECTOR Hanson Funeral Home		ADDRESS 4774 W. 34th St. N.W.		25a. REC'D BY REGISTRAR APR 19 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in Pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05649

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05649

1 PLACE OF DEATH a. COUNTY Prince George's				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b DOA			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) Richard Ashby Kidwell				4 DATE OF DEATH Month 4 Day 13 Year 19 67			
5 SEX Male		6 COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH 17 June 1893	
9 AGE (In years, lost birthday) 73 yrs.		10a USUAL OCCUPATION (Give kind of work done during last working life, even if retired) Retired Engineer		10b KIND OF BUSINESS OR INDUSTRY U of Md		11 BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U S A				13 FATHER'S NAME John F. Kidwell			
14. MOTHER'S MAIDEN NAME Susan B Campbell				15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no			
16 SOCIAL SECURITY NO. 578 07 8579A				17. INFORMANT Milburn Florence Address Washington D. C.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH minutes unknown
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 4200							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. 19				20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f (City or town)				20g (County)		20h (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe, M.D.				22. DATE SIGNED 4-14-67			
23a BURIAL, CREMATION, REMOVAL (Specify)				23b DATE THEREOF April 17, 1967		23c NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery	
23d LOCAL (City or town)				23e (County)		23f (State) Colmar Manor Pro Geo Md.	
24 FUNERAL DIRECTOR F. Gasch's Sons				ADDRESS Hyattsville, Md.		25a REC'D BY REGISTRAR APR 18 1967	
25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>							

05650

CERTIFICATE OF DEATH

05650

1 PLACE OF DEATH COUNTY PRINCE GEORGES MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND COUNTY PRINCE GEORGES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AF BASE		c. LENGTH OF STAY IN 1b 18 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF HOSPITAL ANDREWS		e. STREET ADDRESS 1312 ALBERTA DRIVE	
3 NAME OF DECEASED (Type or print) First Middle Last ROY FRANKLIN KIMBLE		4. DATE OF DEATH Month Day Year APRIL 20 1967	
5 SEX MALE	6. COLOR OR RACE CAU	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9 JUNE 1921
9. AGE (In years last birthday) 45 yrs		10. FUNDING YEAR Months Days Hours Min. 45	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) US AIR FORCE		10b. KIND OF BUSINESS OR INDUSTRY USAF	
11. BIRTHPLACE (County & State, or foreign country) LEECO, KENTUCKY		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME HENRY KIMBLE		14. MOTHER'S MAIDEN NAME FLOSSIE E. ASH	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES APR 51-JUN 67		16. SOCIAL SECURITY NO. 235-24-3613	
17. INFORMANT WIFE		Address SAME AS #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1967 IMMEDIATE CAUSE (a) METASTATIC CARCINOMA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (he/she) attended the deceased from 2 April 1967 , to 20 April 1967 , that (he/she) last saw the deceased alive on 20 April 1967 , and that death occurred at 8:40 A.M. from causes and on the date stated above.			
22a. SIGNATURE <i>Robert R. Mitchell</i>		22b. DATE SIGNED 20 Apr 67	
22c. PHYSICIAN'S NAME (Type) ROBERT R. MITCHELL, CAPT USAF MC		22d. ADDRESS USAF Hospital Andrews Andrews AFB, Wash DC 20331	
23a. BURIAL, CREMATION REMOVAL (Specify) BURIAL	23b. DATE THEREOF 4/25/67	23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL	23d. LOCATION (City or Town) (County) (State) ARLINGTON, VIRGINIA
24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home 4308 Suitland Road, Suitland, Maryland		25a. REC'D BY REGISTRAR DATE APR 25 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then page 4 should be removed, and if any event, within 72 hours after death should be filed with the State Dept. of Health prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

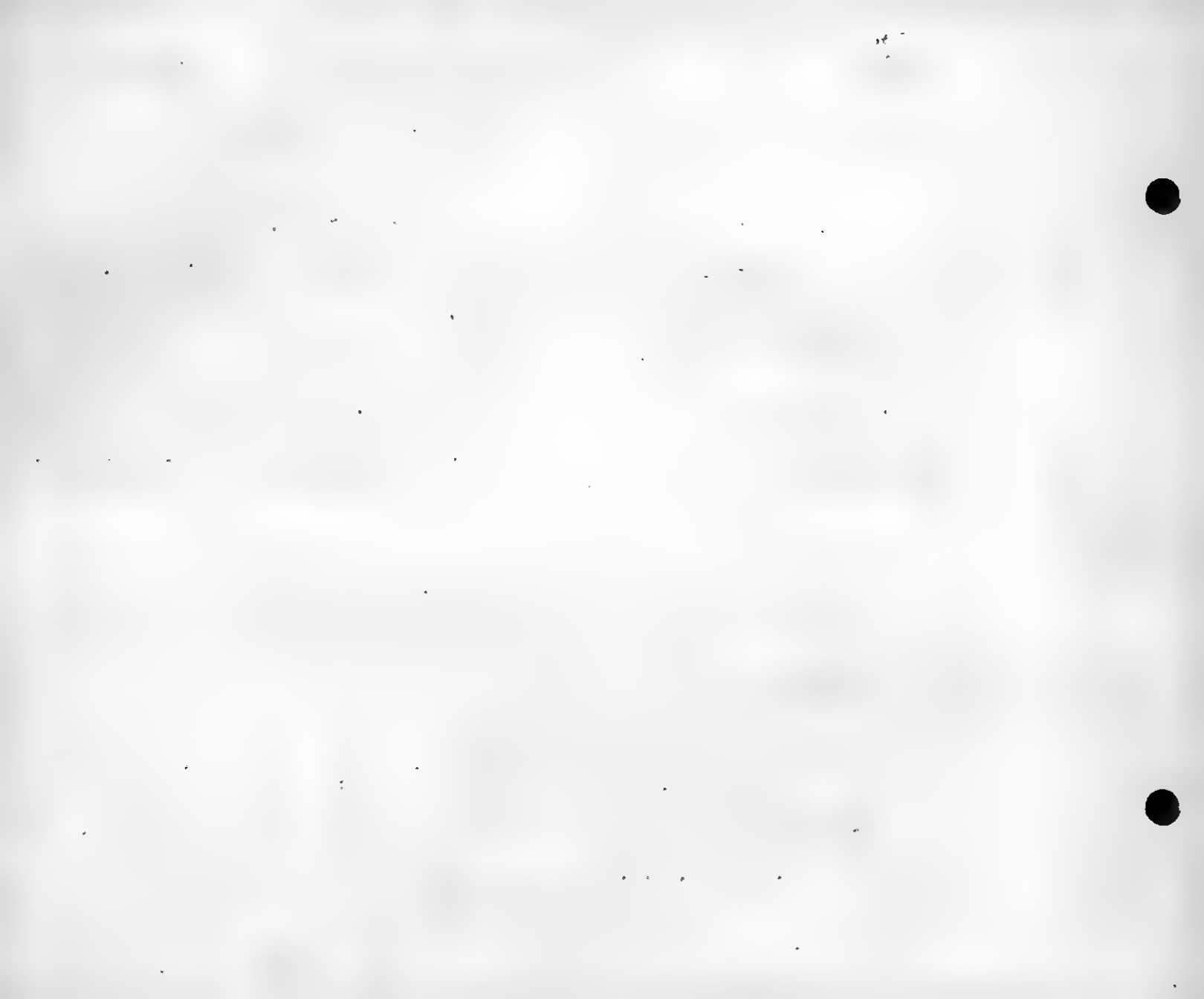
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05651

CERTIFICATE OF DEATH

05651

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 10 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. STREET ADDRESS 5317 Cheseapeake St.	
3. NAME OF DECEASED (Type or print) First Middle Last Marion Mae Kraus		4. DATE OF DEATH Month Day Year April 23, 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 6/4/04
9. AGE (In years lost birthday) yrs. 62		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED NURSE	11. BIRTHPLACE (County & State, or foreign country) PENNA.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME JOHN T. THOMAS	
14. MOTHER'S MAIDEN NAME ELEANOR E. GRANT		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO	
16. SOCIAL SECURITY NO.		17. INFORMANT Address RUTH E. FOSTER 4604 KANSAS AVE. N.W. WASH. D.C.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Severe Congestive Heart Failure DUE TO Coronary Arteriosclerotic Heart Disease DUE TO Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that this hospital attended the deceased from April 13, 1967, to April 23, 1967, that (it) (we) last saw the deceased alive on April 23, 1967, and that death occurred at 10:50 AM, from causes and on the date stated above.			
22a. SIGNATURE Edwin J. Jensen		22b. DATE SIGNED April 24, 1967	
22c. PHYSICIAN'S NAME (Type) Edwin J. Jensen, M.D.		22d. ADDRESS Prince Georges General Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION	23b. DATE THEREOF 4/26/67	23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY	23d. LOCATION (City or Town) (County) (State) PRINCE GEORGES, MARYLAND
24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home 4308 Suitland Road, Suitland, Maryland		25a. REC'D BY REGISTRAR DATE APR 26 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



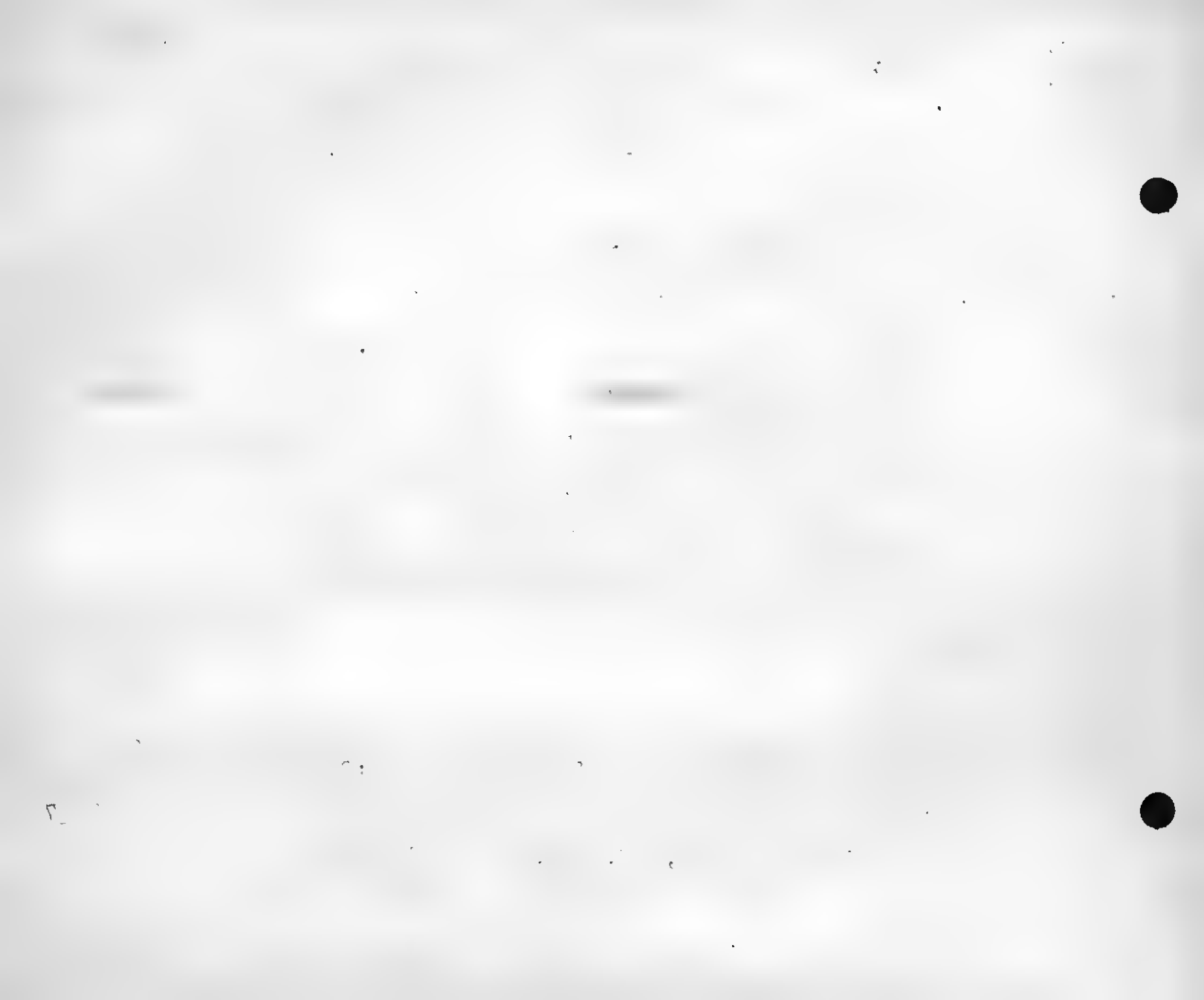
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
05652 CERTIFICATE OF DEATH 05652									
1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ANDREWS AFB			c. LENGTH OF STAY IN 1b 1 DAY		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CAMP SPRINGS				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) USAF HOSPITAL ANDREWS					d. STREET ADDRESS 6602 VELTRI DRIVE			b. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ELIZABETH Middle BYRD Last KREIS					4. DATE OF DEATH Month APRIL Day 28 Year 1967				
5. SEX FEMALE		6. COLOR OR RACE CAU		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2 OCT 71		9. AGE (In years last birthday) 95 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) BLAND CO. VIRGINIA			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME PHILIP ANDERSON					14. MOTHER'S MAIDEN NAME ELIZABETH BLAND				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Son		Address Same as 2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CENTRAL NERVOUS SYSTEM INVOLVEMENT DUE TO (c) SEVERE MALNUTRITION AND DEHYDRATION									INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 27 APRIL , 19 67 , to 28 APRIL , 19 67 , that (I) (we) last saw the deceased alive on 28 APRIL , 19 67 , and that death occurred at 11:00 AM , from the causes and on the date stated above.									
22a. SIGNATURE <i>David E. Langdon</i> Attending USAF M.E.					22b. DATE SIGNED 28 APRIL 67			22c. PHYSICIAN'S NAME (Type) JOHN SIMONAITIS, MAJ, USAF, MC	
22d. ADDRESS USAF HOSP ANDREWS AFB WASH DC 20331									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 5/1/67		23c. NAME OF CEMETERY OR CREMATORY MONTE VISTA PARK		23d. LOCATION (City, town or county) (State) BLUEFIELD, W. VA.			
24. FUNERAL DIRECTOR W.W. CHAMBERS CO. INC. WASHINGTON DC					25a. REC'D BY REGISTRAR W.A. 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

MEDICAL CERTIFICATION



05653

CERTIFICATE OF DEATH

05653

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince Georges		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 13 days		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital						d. STREET ADDRESS RFD, Box 4570		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Albert F. Labrecque		4. DATE OF DEATH Month April Day 21 Year 19 67		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> Sep. DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Jan. 9, 1892		9. AGE (In years last birthday) 75 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (County & State, or foreign country) Vermont	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes W.W.I		16. SOCIAL SECURITY NO 029-01-23864	
17. INFORMANT George A. La Breoque		18. ADDRESS 2214 Olson Court Marlow Hgts, Md		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) C.V.A. (Cerebral Vascular Accident) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 231X DUE TO (c) 231X					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Myocardial infarct						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)		21. I certify that (I) (the deceased) attended the deceased from Jan 19 66 to April 21, 1967 , that (I) (we) last saw the deceased alive on April 21, 1967 , and that death occurred at 8:25 AM , from causes and on the date stated above.			
22a. SIGNATURE <i>[Signature]</i>		22b. DATE SIGNED 4/21/67		22c. PHYSICIAN'S NAME (Type) A. Clark Holmes, M.D.		22d. ADDRESS 4108 Pratt St., Upper Marlboro, Maryland		22e. MED. DIRECTOR <input checked="" type="checkbox"/> MED. STAFF <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/24/1967		23c. NAME OF CEMETERY OR CREMATORY Monson, Mass.		23d. LOCATION (City or Town) (County) (State)		24. FUNERAL DIRECTOR W.W. Chambers Co. Inc. Washington, D.C.	
25a. REC'D BY REGISTRAR APR 25 1967		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		25c. REGISTRAR'S NAME J. Charles Judge					



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

(M)

05654

05654

1 PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George's General</u>				d. STREET ADDRESS <u>5705 31st Ave.</u>			
3 NAME OF DECEASED (Type or print) <u>Mary T. Laycock</u>				4 DATE OF DEATH Month <u>April</u> Day <u>1</u> Year <u>1967</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-24-1899</u>	
9. AGE (In years last birthday) <u>67</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manager</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Wash. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Heale</u>				14. MOTHER'S MAIDEN NAME <u>Annie Sanford</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO <u>579-32-3944</u>		17. INFORMANT <u>Catherine Cole</u> Address <u>5705-31st Ave Hyattsville Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of ovary</u> DUE TO (b) <u>Cocaine</u> DUE TO (c) <u>Stroke</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>MARCH 13</u>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>MARCH 13</u> , 19 <u>67</u> , to <u>April 1</u> , 19 <u>67</u> , that (I) (we) lost the deceased alive on <u>April 1</u> , 19 <u>67</u> , and that death occurred at <u>6:55 PM</u> , from causes and on the date stated above							
22a. SIGNATURE <u>Leon R. Levitsky</u>				22b. DATE SIGNED <u>4/3/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>Leon R. Levitsky</u>				22d. ADDRESS <u>3408-91st Ave N.W. Washington, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>4-5-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Elizabeth's</u>		23d. LOCATION (City or town) (County) (State) <u>Wash. D.C.</u>	
24. FUNERAL DIRECTOR <u>William J. 131-11th St S.E. Wash D.C.</u>				25a. REC'D BY REGISTRAR DATE <u>APR 5 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION

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1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05655

CERTIFICATE OF DEATH

05655

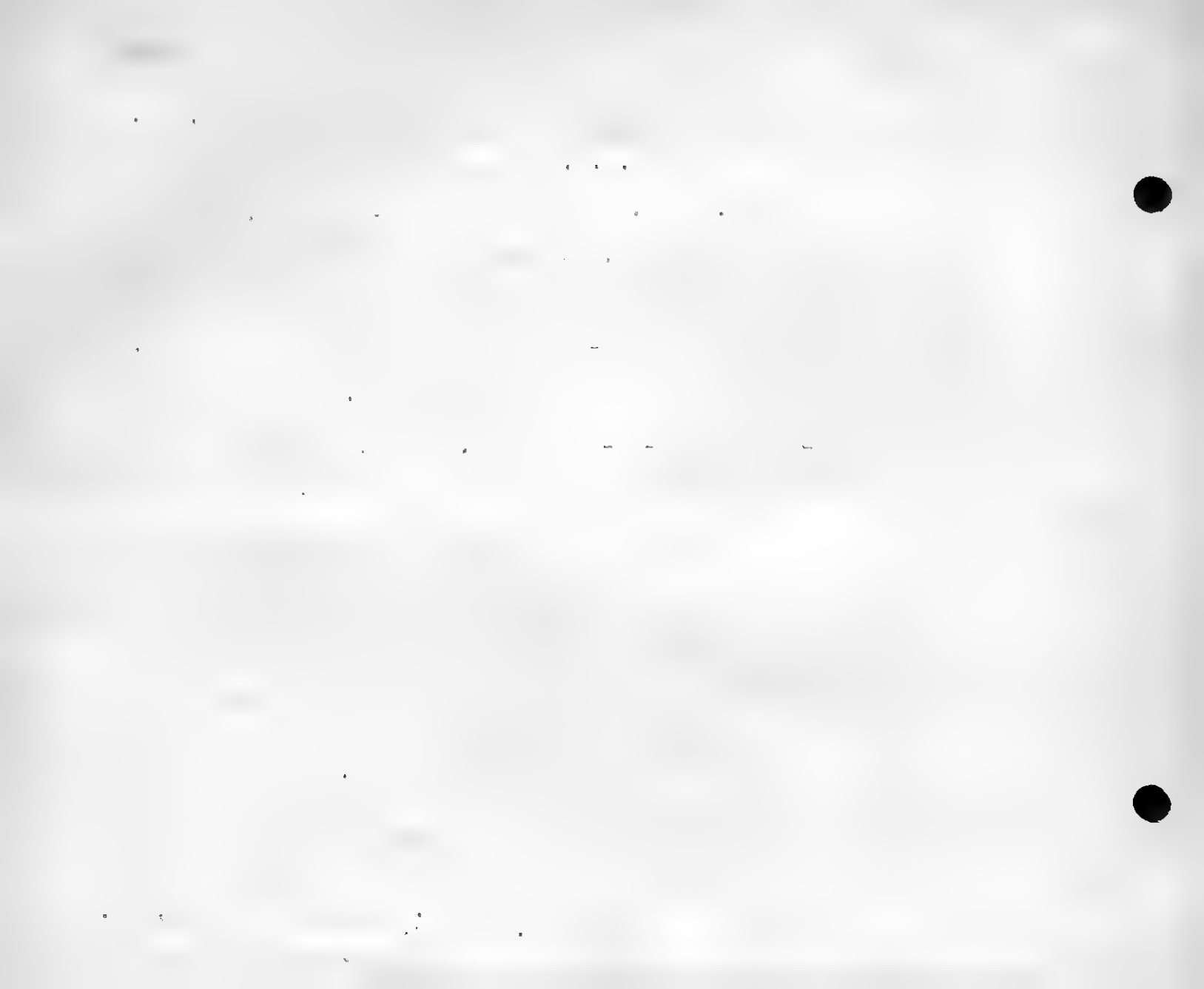
1 PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesverly		c. LENGTH OF STAY IN 1b 31 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. STREET ADDRESS (Vincent's Trailer Ct.) 3200 Kenilworth Ave.	
3 NAME OF DECEASED (Type or print) First Middle Last William N Lemmons		4 DATE OF DEATH Month Day Year 8 April 19 67	
5 SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 27 May 1906
9. AGE (In years lost birthday) yrs 60		10. IF UNDER 1 Year Months Days Hours Min. 4 19 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard		10b. KIND OF BUSINESS OR INDUSTRY Detective	
11. BIRTHPLACE (County & State, or foreign country) North Carolina		12. CITIZENSHIP OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lester A. Lemmons		14. MOTHER'S MAIDEN NAME Nancy Jane Blanton	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO 213 12 1815	
17. INFORMANT Dorothy I. Lemmons		Address Same as #2 (wife)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u><i>Brain Arteriosclerosis</i></u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u><i>6 weeks</i></u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u><i>3/4/1967</i></u> to <u><i>4/4/1967</i></u> , that (I) (<u><i>we</i></u>) last saw the deceased alive on <u><i>4/3/1967</i></u> , and that death occurred at <u><i>7:00A</i></u> M, from causes and on the date stated above.			
22a. SIGNATURE <u><i>[Signature]</i></u> M.D.		22b. DATE SIGNED <u><i>4/4/67</i></u>	
22c. PHYSICIAN'S NAME (Type) <u><i>F E M U S S E R</i></u>		22d. ADDRESS <u><i>4410 24th Ave Beltsville Md</i></u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4/6/67	23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln	23d. LOCATION (City or Town) (County) (State) Colmar Manor P.G. Md.
24. FUNERAL DIRECTOR Francis Gasch's Sons		ADDRESS Hyattsville, Md.	
25a. REC'D BY REGISTRAR APR 6 1967		25b. REGISTRAR'S SIGNATURE <u><i>[Signature]</i></u>	

OK by Dr John Kehoe

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
05656					05658						
1. PLACE OF DEATH a. COUNTY Prince George					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Riverdale			c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Beltsville						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Eugene Leland Mem. Hosp.					d. STREET ADDRESS 11630 - 36th Pl.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Clarence		Middle P. T.		Last Lockhart		4. DATE OF DEATH Month April		Day 13, 1967			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/14/1916		9. AGE (In years last birthday) 50 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Boil Vending Machine			10b. KIND OF BUSINESS OR INDUSTRY -			11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Howard T. Lockhart					14. MOTHER'S MAIDEN NAME Minnie E. Orndorff						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 578-01-1771		17. INFORMANT Mrs. Mary H. Lockhart (above address)						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis, ACUTE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>16 yrs</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>10 yrs</u>										INTERVAL BETWEEN ONSET AND DEATH <u>16 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>5/25</u> <u>4-4-1966</u> to <u>4/13</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4/4</u> , 19 <u>67</u> , and that death occurred at <u>4</u> A.M., from the causes and on the date stated above.										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22a. SIGNATURE <u>Norman D. Conean</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4/14/67</u>		
22c. PHYSICIAN'S NAME (Type) <u>Norman D. Conean</u>					22d. ADDRESS <u>3503 Pennys Mt Rainier</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>4/15/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Com.</u>			23d. LOCATION (City, town or county) (State) <u>Colmar Manor, Md.</u>			
24. FUNERAL DIRECTOR <u>Nalley's Funeral Home Inc.</u>					ADDRESS <u>Mt. Rainier Maryland</u>		REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



CERTIFICATE OF DEATH

05657

05657

1. PLACE OF DEATH a. COUNTY <u>Prince Georges Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>DC</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington DC</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Southern Md General Hosp</u>		d. STREET ADDRESS <u>4810 Illinois Ave N.W.</u>	
3. NAME OF DECEASED (Type or print) <u>MARY</u>		4. DATE OF DEATH Month <u>4</u> Day <u>21</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>4/23/25</u>
9. AGE (In years last birthday) <u>41</u> yrs		10. IF UNDER 1 YEAR Months <u>21</u> Days <u>19</u> Hours <u>67</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>typist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. govt</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Cincinnati Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM C. BELL</u>		14. MOTHER'S MAIDEN NAME <u>LILLIAN COATES</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>2805 MONROE, N.E.</u>	
17. INFORMANT <u>LILLIAN RUTHERFORD</u>		<u>WASH., D.C.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> 578X DUE TO <u>Respiratory Embarrassment</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>marked Distension of Small Bowel</u> (c) <u>Obstruction</u>			INTERVAL BETWEEN ONSET AND DEATH <u>14 min</u> <u>8 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4/20</u> , 19 <u>67</u> , to <u>4/21</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4/21</u> , 19 <u>67</u> , and that death occurred at <u>4:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Steven Christian M.D.</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>STEVEN CRISTIAN M.D.</u>		22d. ADDRESS <u>1534 16th St. N.W. Washington DC</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4.26.67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVE CEMETERY</u>		23d. LOCATION (City or Town) (County) (State) <u>WASHINGTON, D.C.</u>	
24. FUNERAL DIRECTOR <u>McCounes Funeral Service</u>		25a. REC'D BY REGISTRAR <u>1820-958 N.W.</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>APR 24 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed with the attending physician and completed by the funeral director, page 3 should be detached for use as the burial permit. Then please remove the certificate from the file and file with the State Dept. of Health prior to burial, cremation, or removal, and in proper order with the State Dept. of Health.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial permit. Then please remove the certificate from the file and file with the State Dept. of Health prior to burial, cremation, or removal, and in proper order with the State Dept. of Health.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05658

05658

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS 4417 Tonquil St.	
3 NAME OF DECEASED (Type or print) First Middle Last Cora E. Lowe		4. DATE OF DEATH Month Day Year April 7, 19 67	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 7/19/64
9 AGE (In years last birthday) 72 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME WILLIAM THOMAS	
14. MOTHER'S MAIDEN NAME LUCY PURNELL		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO	
16. SOCIAL SECURITY NO. 579 09 4377		17. INFORMANT MRS MARY C. DOLAN Address SAME AS #2	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary embolism fatal DUE TO PULMONARY EMBOLISM Left (b) Pulmonary infarction left lower lobe DUE TO Pneumonia (c) Pneumonia Pneumonia 2° ruptured diverticula sigmoid			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 4/3, 1967, to 4/7, 1967, that (I) (we) last saw the deceased alive on April 7, 1967, and that death occurred at 1:10 AM, from causes and on the date stated above.			
22a. SIGNATURE Albert Roth, M. D.		22b. DATE SIGNED 4/7/67	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS 5409 Riverdale Rd., Riverdale, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 4-10-1967	23c. NAME OF CEMETERY OR CREMATORY FALCON CEM.	23d. LOCATION (City or Town) (County) (State) BLADENSBURG MARYLAND
24. FUNERAL DIRECTOR W.W. CHAMBERS Co. RIVERDALE, MD.		25a. REC'D BY REGISTRAR DATE APR 10 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05659

CERTIFICATE OF DEATH

05659

1 PLACE OF DEATH a. COUNTY <i>Prince Georges County</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince Georges</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>1905 Erie Street</i>		d. STREET ADDRESS <i>1905 Erie Street</i>	
3 NAME OF DECEASED (Type or print) <i>James (nm) Lynch</i>		4. DATE OF DEATH Month <i>Apr</i> Day <i>24</i> Year <i>1967</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov 21, 1889</i>
9. AGE (In years lost birthday) <i>77</i> yrs		10. IF UNDER 1 YEAR Months <i>24</i> Days <i>19</i> Hours <i>67</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Claims Examiner</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Air Force</i>	
11. BIRTHPLACE (County & State or foreign country) <i>England</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>William P. Lynch</i>		14. MOTHER'S MAIDEN NAME <i>Catherine Mc Keever</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>yes</i>		16. SOCIAL SECURITY NO <i>578-32-4863-A</i>	
17. INFORMANT <i>Mrs. Mary Lynch</i>		Address <i>1905 Erie Street Hyattsville, Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Heart Disease</i> DUE TO (b) <i>Arteriosclerosis Generalized</i> DUE TO (c) <i>15 yrs.</i>			INTERVAL BETWEEN ONSET AND DEATH <i>7 yrs.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>1946</i> , 19 <i>3</i> , to <i>4/24/67</i> , 19 <i>4</i> , that (I) (we) last saw the deceased alive on <i>19 AM 1967</i> , and that death occurred at <i>11 PM</i> , from causes and on the date stated above.			
22a. SIGNATURE <i>G. B. Queen</i>		22b. DATE SIGNED <i>4/25/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>G. B. Queen</i>		22d. ADDRESS <i>344 University Blvd. W., S. S., Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Apr 28, 1967</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Alexandria Nat'l Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Alexandria Virginia</i>	
24. FUNERAL DIRECTOR <i>John B. Thomas Warner E. Humphrey, Inc.</i>		25a. REC'D BY REGISTRAR <i>APR 28 1967</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

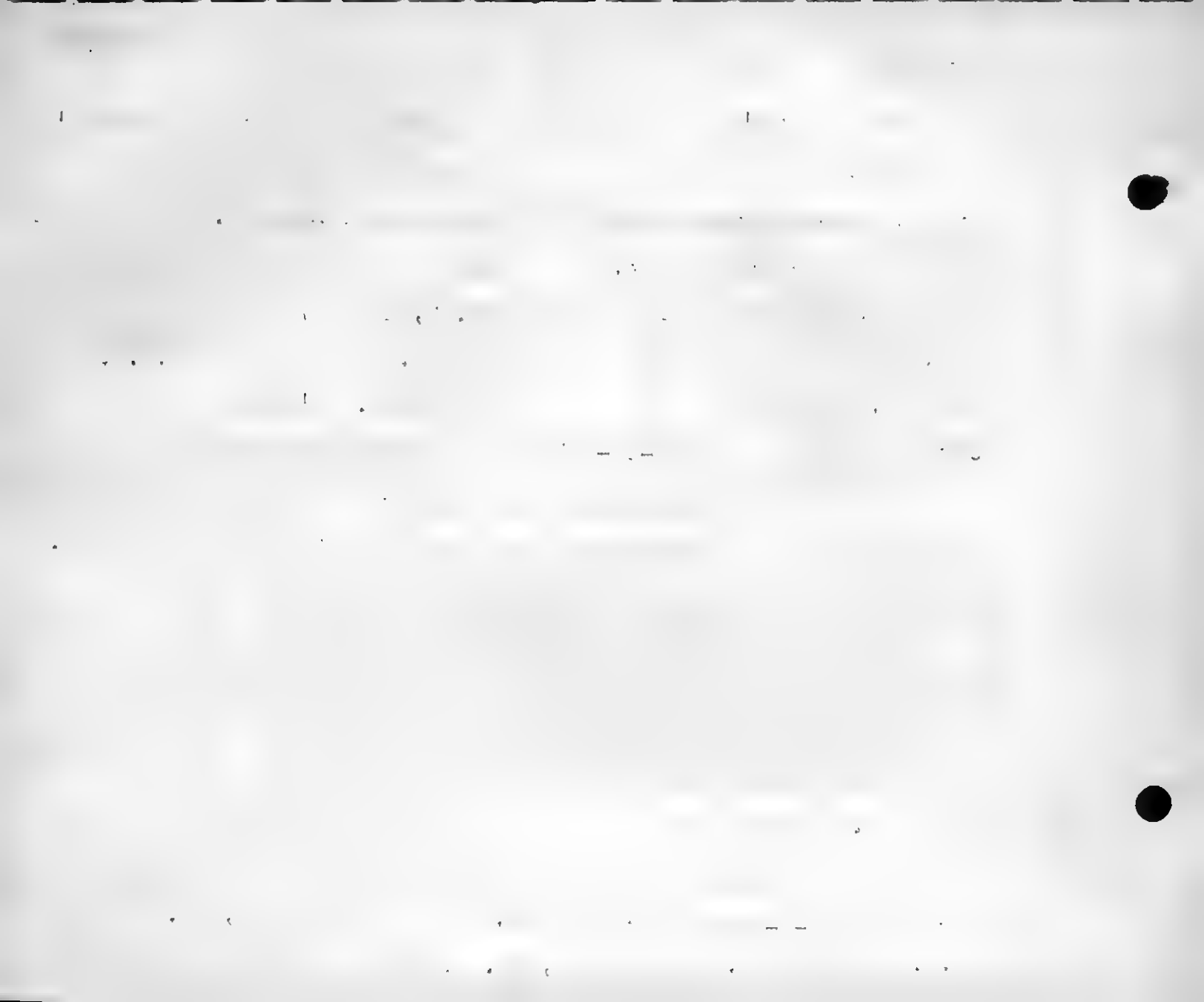
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
05660 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Adelphi c. LENGTH OF STAY IN ID MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Paint Branch Nursing Home					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Adelphi unknown d. STREET ADDRESS 3120 Powder Mill Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) John A. Mahan					4. DATE OF DEATH April 28 1967					
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 2, 1893		9. AGE (In years last birthday) 73 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Penna.			12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John J. Mahan					14. MOTHER'S MAIDEN NAME Agnes B. O'Connell					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. 579-10-3022		17. INFORMANT Paint Branch Nursing Home Records Address						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) 10 yrs.								INTERVAL BETWEEN ONSET AND DEATH 2 days		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE John Kehoe MD					22. DATE SIGNED 5-1-67					
EXAMINER'S NAME (Type) John Kehoe M.D.					DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF 5-2-1967		23c. NAME OF CEMETERY OR CREMATORY Harmony Cem.		23d. LOCATION (City, town or county) (State) Landover, Md.	
24. FUNERAL DIRECTOR W.W. Chambers Co.					ADDRESS Riverdale, Md.		25a. REC'D BY REGISTRAR MAY 8 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



05661

CERTIFICATE OF DEATH

05661

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS 5800 64th Ave.	
3. NAME OF DECEASED (Type or print) First Middle Last Carrie R. Martin		4 DATE OF DEATH Month Day Year April 7, 1967	
5 SEX Female	6 COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/14/99
9 AGE (n years last birthday) 67 yrs		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME William A Fawcett		14. MOTHER'S MAIDEN NAME Alice May Keene	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO	
17. INFORMANT George Carrick		Address Riverdale, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Pulmonary emboli 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerotic Cardiovascular Disease DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hypertension Left Kidney			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from July, 1966, to 4/7, 1967, that (I) (we) last saw the deceased alive on 19 and that death occurred at 4:25 AM, from causes and on the date stated above.			
22a. SIGNATURE William D. Rosson M.D.		22b. DATE SIGNED 4/7/67	
22c. PHYSICIAN'S NAME (Type) Dr. William D. Rosson		22d. ADDRESS 5701 85th Ave., Hyattsville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF April 10, 1967	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d. LOCATION (City or town) (County) (State) Suitland Pro Geo Md.
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE APR 10 1967	25b. REGISTER'S SIGNATURE Judge

CERTIFICATE OF DEATH

05662

05662

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD. b. COUNTY District of Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 1 day	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS 1216 61st Ave., S.E.	
3. NAME OF DECEASED (Type or print) First John Middle B. Last McAfee		4. DATE OF DEATH Month April Day 15 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 3/27/96
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Printer		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government	9. AGE (In years) 71 (lost birthday) yrs
11. BIRTHPLACE (County & State or foreign country) Washington D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles McAfee		14. MOTHER'S MAIDEN NAME Carrie Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 8		16. SOCIAL SECURITY NO	
17. INFORMANT Abbie H. McAfee		Address Same As # 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute Pulmonary Edema 5272 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (s) (this hospital) attended the deceased from April 14, 1967 , to April 15, 1967 , that (s) (we) last saw the deceased alive on April 15, 1967 , and that death occurred at 12:40 PM , from causes and on the date stated above.			
22a. SIGNATURE Lawrence J. Lieberman		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED APRIL 15, 1967
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4/18/67	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Prince Georges, Maryland
24. FUNERAL DIRECTOR Robert E. Wilhelm		ADDRESS 4308 Southland Rd Southland Md	25a. REC'D BY REGISTRAR APR 19 1967
		25b. REGISTRAR'S SIGNATURE John J. Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If July day is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05663

05663

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution; Res. before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Maryland Park			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital				d. STREET ADDRESS 6410 Coolidge Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last Gladys A. McClanahan				4 DATE OF DEATH Month Day Year 4 17 67			
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 12-16-96		9 AGE (In years last birthday) 70 yrs	10 IF UNDER 1 YEAR Months Days 17 19 67	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) VIRGINIA		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME WILLIAM HETLIN				14 MOTHER'S MAIDEN NAME ISABELLE VOGT			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 579-05-8889A		17 INFORMANT Address MRS. EUNICE NASH WINTER CATLETT, VA.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH minutes over 2 mo.
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)					
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>John Kehoe</i> EXAMINER'S NAME Type, John Kehoe, M.D. Riverdale, Md.				22. DATE SIGNED 4-18-67.			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE THEREOF		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or town) (County) (State)	
BURIAL		APRIL 22, 1967		CEDAR RUN CEM.		SOUEGO, VA.	
24 FUNERAL DIRECTOR W. W. CHAMBERS CO. RIVERDALE, MD.				25a REC'D BY REGISTRAR APR 24 1967		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05664

05664

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>VIRGINIA</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FORESTVILLE</u>		c. LENGTH OF STAY IN 1b <u>2 WEEKS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ALEXANDRIA</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>REGENT NURSING HOME</u>				d. STREET ADDRESS <u>624 NORTH WASHINGTON</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>PATRICK H. McCloskey</u>				4. DATE OF DEATH Month <u>4</u> Day <u>14</u> Year <u>1967</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>APR 3, 1905</u>	
9. AGE (In years last birthday) yrs <u>62</u>		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>		11. BIRTHPLACE (County & State or foreign country) <u>NEW CASTLE, ENG.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WAREHOUSE MAN</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>GENERAL</u>		13. FATHER'S NAME <u>JAMES MC CLOSKEY</u>	
13. FATHER'S NAME <u>JAMES MC CLOSKEY</u>				14. MOTHER'S MAIDEN NAME <u>MARGARET UNK</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES WWII 1941-1945</u>				16. SOCIAL SECURITY NO. <u>167 12 7177</u>		17. INFORMANT Address <u>Phila Pa</u> <u>TERESA FLYNN - 5951 NORWOOD ST</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>metastatic melanoma to brain</u> DUE TO (b) <u>Melano Carcinoma of the left neck</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 YRS.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <u>MAR 1, 1967</u> , to <u>APR 14, 1967</u> , that (4) (we) last saw the deceased alive on <u>APR 14, 1967</u> , and that death occurred at <u>3:06 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>W B Steer</u>				22b. DATE SIGNED <u>4-14-67</u>		22c. PHYSICIAN'S NAME (Type) <u>WALTER B. STEER M.D.</u>	
22c. PHYSICIAN'S NAME (Type) <u>WALTER B. STEER M.D.</u>				22d. ADDRESS <u>6400 MARLBORO PIKE S.E. WASH. D.C. 20028</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4/20/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ALEXANDRIA NATL</u>		23d. LOCATION (City or Town) (County) (State) <u>ALEXANDRIA VA</u>	
24. FUNERAL DIRECTOR <u>W.W. Chambers Co. Inc</u>				25a. REC'D BY REGISTRAR <u>APR 18 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05665

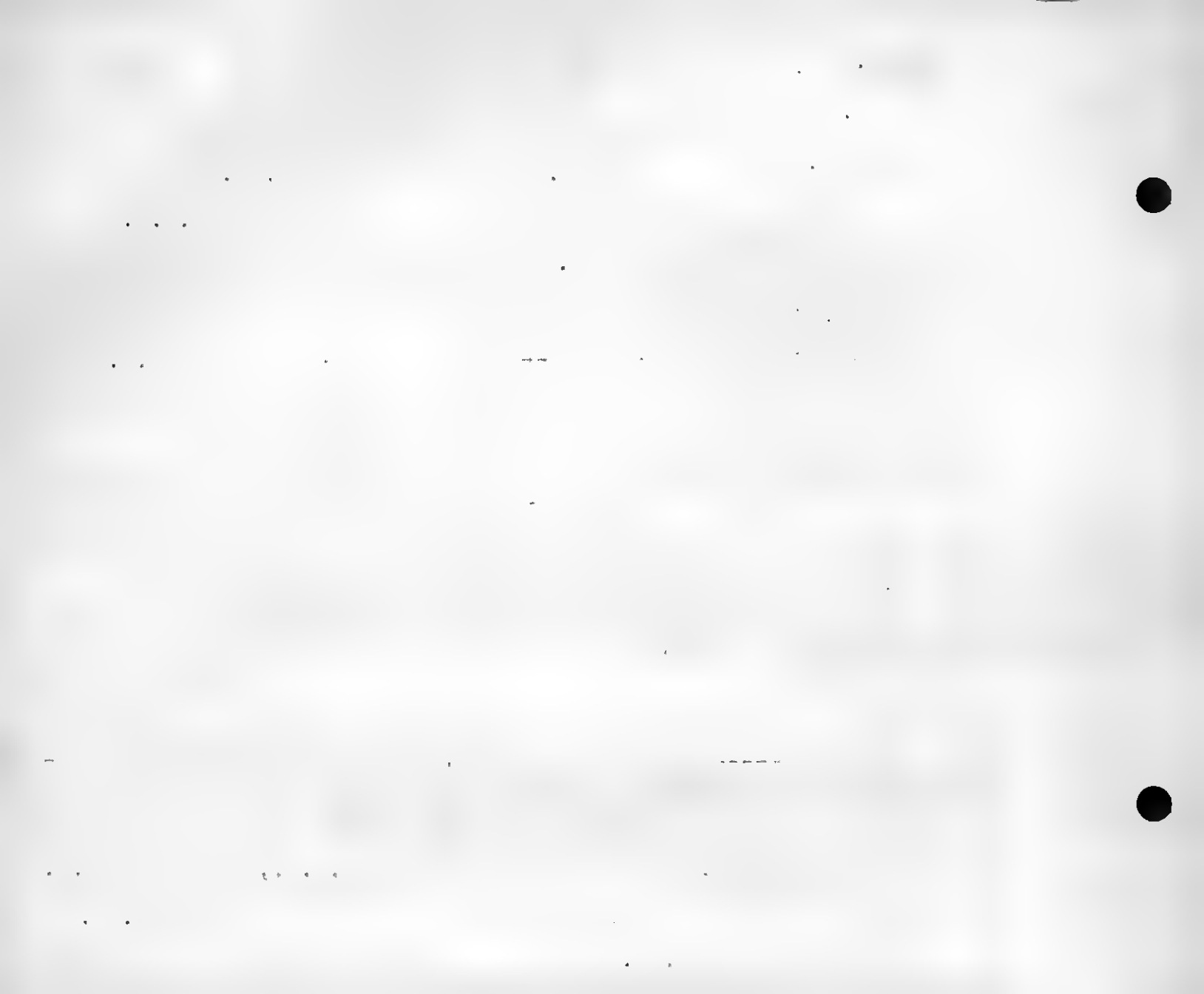
CERTIFICATE OF DEATH

05665

1 PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on. Residence before admission) a. STATE b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. LENGTH OF STAY IN 1b 7 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Carroll Manor		d. STREET ADDRESS 2900 Connecticut Ave. N.W.	
3 NAME OF DECEASED (Type or print) Josephine A. McDevitt		4 DATE OF DEATH Month 4 Day 20 Year 1967	
5 SEX female	6 COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 7/1/1881
10a. USUA. OCCUPAT ON (Give kind of work done during most of working life, except retired) Clerk - Smithsonian Institution		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) Washington, DC		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME James McDevitt		14. MOTHER'S MAIDEN NAME Unobtainable	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Carroll Manor Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Hemorrhage DUE TO (b) Hypertension DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
INTERVAL BETWEEN ONSET AND DEATH 10 days 10 years			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hemiplegia 8 years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Sept. 9, 1960 to April 20, 1967 , that (I) (we) last saw the deceased alive on April 17, 1967 , and that death occurred at 6 AM , from causes and on the date stated above.			
22a. SIGNATURE Thomas F. Collins		22b. DATE SIGNED April 20, 67	
22c. PHYSICIAN'S NAME (Type) Thomas F. Collins		22d. ADDRESS 322 H St. N.E., Washington, D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4/22/67	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	23d. LOCATION (City or Town) (County) (State) Washington, D. C.
24. FUNERAL DIRECTOR The S. H. Hines Company		25a. REC'D BY REGISTRAR APR 24 1967	
ADDRESS Washington, D.C.		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the undersigned, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05666

CERTIFICATE OF DEATH

05667

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b D O A		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS 407 Addison Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Michael Middle Joseph Last McGarry		4. DATE OF DEATH Month April Day 6 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 1, 1894 9. AGE (In years last birthday) 72 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (County & State, or foreign country) Washington D. C.		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Patrick McGarry		14. MOTHER'S MAIDEN NAME Julia Carr	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 213 38 2218	
17. INFORMANT Anna McGarry		Address Same as #2 (wife)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 4201 DUE TO CORONARY & MYOCARDIAL OCCLUSION INFARCTION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) DUE TO CORONARY HEART DISEASE (c) DUE TO HYPERTENSIVE CARDIO-VASC. DISEASE & INTERMITTENT CLAUDICATION		INTERVAL BETWEEN ONSET AND DEATH INSTANT DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan - 19 58 to Feb - 19 67 , that (I) (we) last saw the deceased alive on FEB - 4 1967 , and that death occurred at 11:20 AM , from causes and on the date stated above.			
22a. SIGNATURE Max M. Herzberg		22b. DATE SIGNED 4-6-1967	
22c. PHYSICIAN'S NAME (Type) Dr. Max M. Herzberg		22d. ADDRESS 3308 Dodge Pk. Rd., Landover, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4/10/67	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet	23d. LOCATION (City or Town) (County) (State) Washington D. C.
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE APR 10 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove bottom papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
AM 1-67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05667

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05666

1 PLACE OF DEATH a COUNTY Prince George's b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c LENGTH OF STAY IN IL DOA		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b COUNTY Prince George's c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxon Hill	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		e STREET ADDRESS 418 Maurey Avenue		f IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last William A McNab		4 DATE OF DEATH Month Day Year 4 22 1967		5 AGE (In years last birthday) 33 yrs	
6 SEX male	7 COLOR OR RACE white	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 DATE OF BIRTH 12-16-1933	10 IF UNDER 1 YEAR Months Days Hours Min	11 IF UNDER 24 HRS Months Days Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Driver		10b KIND OF BUSINESS OR INDUSTRY Trucking		11 BIRTHPLACE (State or foreign country) New Jersey	
12 CITIZEN OF WHAT COUNTRY? USA		13 FATHER'S NAME George E. McNab		14 MOTHER'S MAIDEN NAME Norma Swartzman	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) Yes N/A		16 SOCIAL SECURITY NO 579 38 2655		17 INFORMANT George McNab - Bro Address Rt 1. Bx 265 Clinton. Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Laceration of brain DUE TO Trauma - motorcycle accident. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c)					INTERVAL BETWEEN ONSET AND DEATH
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) Driver of motorcycle which ran into parked car.			
20c TIME OF INJURY Month Day Year Hour a.m. 10:55pm 4-22- 1967		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work		20e PLACE OF INJURY (Home farm factory street, office bldg, etc.) 400 Maurey Ave., Oxon Hill, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John Kehoe		EXAMINER'S NAME Type John Kehoe, M.D.		22. DATE SIGNED 4-24-67	
23a BIRTH CREMATION, REMOVAL (Specify)		23b DATE THEREOF 4/26/67		23c NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	
24 FUNERAL DIRECTOR Lee Funeral Home, 300 4th NE. Wash. DC		23d LOCATION (City or town) (County) (State) Suitland, Maryland		25a REC'D BY REGISTRAR APR 27 1967	
				25b REGISTRAR'S SIGNATURE Charles Judge	

may be retained in hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items #1c, 8 & 9, 11, 12, 13, 14, 15/67 pc

05668

CERTIFICATE OF DEATH

Reg. Dist. No. 05668

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Avondale		c. LENGTH OF STAY IN 1b 10 11/4 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Avondale			
d. NAME OF HOSPITAL (If not in hospital, give street address) 4827 Russell Avenue				d. STREET ADDRESS 4827 Russell Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JAMES J. MCPADDEN SR.				4. DATE OF DEATH Month April Day 10 Year 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 1 1888	9. AGE (In years and birthday) 79 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Trucker		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Ireland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Hugh McPadden				14. MOTHER'S MAIDEN NAME Mary Flynn			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) -		17. INFORMANT Wife		Address 4827 Russell Ave, Hyatts.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Failure 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Coronary artery Disease. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 3 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January, 1967 to April 10, 1967 , that I last saw the deceased alive on 10 April 1967 , and that death occurred at 2:30 p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Hyattsville, Md. DATE SIGNED 11 Apr 67							
ACTUAL SIGNATURE Wm. A. Wimsatt		M.D. William A Wimsatt M.D. 3415 Hamilton Street, Hyattsville, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/14/67		22c. NAME OF CEMETERY OR CREMATORY Gate Of Heaven Cemetery White Plains, N.Y.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Nalley Funeral Home				ADDRESS Mt Rainier, Maryland		24a. REC'D BY REGISTRAR APR 14 1967	
				24b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05663

CERTIFICATE OF DEATH

05669

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if instit on Residence before admision) a. STATE Maryland b. COUNTY Anna Arundle	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Odenton	
c. LENGTH OF STAY IN lb 14 days		d. STREET ADDRESS Rt. 1 Box 520 Evergreen Rd.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Samuel McVea		4. DATE OF DEATH Month Day Year April 3 19 67	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4 March 1892
9. AGE (In years lost birthday) 75 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Coalminer	
11. BIRTHPLACE (County & State, or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Perry McVea		14. MOTHER'S MAIDEN NAME Addie Tate	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Mrs Julia McVea		Address Samaras 2D	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Circulatory Failure. 592X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) uremia DUE TO (c) chronic glomerular nephritis			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) old myocardial infarction			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (this hospital) attended the deceased from March 20, 1967 , to April 3, 1967 , that (we) last saw the deceased alive on April 3, 1967 , and that death occurred at 9:00PM , from causes and on the date stated above.			
22a. SIGNATURE B. Bahrami		22b. DATE SIGNED 4.4.67	
22c. PHYSICIAN'S NAME (Type) B. Bahrami, M.D.		22d. ADDRESS 3003 N. Y. P. Rd, S.B., D.C.	
23a. BURIAL (CREMATION, REMOVAL) (Specify) REMOVAL	23b. DATE THEREOF 4-5-67	23c. NAME OF CEMETERY OR CREMATORY Whitman's	23d. LOCATION (City or Town) (County) (State) Logan West Virginia
24. FUNERAL DIRECTOR H.S. Wooten		25. REGISTRAR'S SIGNATURE Charles Judge	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 57

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05670

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05670

1 PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b DOA		2 USUAL RESIDENCE (Where deceased lived, if first tuition Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairmont Heights	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		d. STREET ADDRESS 907 60th. Avenue	
3 NAME OF DECEASED (Type or print) Mary Agnes Mennis		4 DATE OF DEATH Month 4 Day 10 Year 1967	
5 SEX Female	6 COLOR OR RACE Negro	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 2 Nov. 1914
9 AGE (in years last birthday) 52		10 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b KIND OF BUSINESS OR INDUSTRY Private family	
11 BIRTHPLACE (State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? U. S. A.	
13 FATHER'S NAME John Burley		14 MOTHER'S M maiden name Annie Harrison	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 577-541427	
17 INFORMANT Elizabeth Marshall		Address Fairmont Hgts 907-60th. Ave	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure DUE TO Hypertensive arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe, M.D. EXAMINER'S NAME (Type)		22. DATE SIGNED 4-10-67	
23a BURIAL OR REMOVAL (Specify) 4-15-67		23b DATE THEREOF	
23c NAME OF CEMETERY OR CREMATORY Harmony		23d LOCATION (City or Town) (County) (State) Highland Park Md	
24 FUNERAL DIRECTOR H. S. Washington Sons ADDRESS 4925 Deane Ave. NE		25a RECEIVED BY REGISTRAR APR 17 1967 DATE	
25b REGISTRAR'S SIGNATURE Charles Juage			

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05671

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05671

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN Ia DOA		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Forestville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				d. STREET ADDRESS 8122 Redwood Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Earl Middle Dykes Last Meunier				4. DATE OF DEATH Month 4 Day 7 Year 19 67			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-1-22		9. AGE (In years last birthday) yrs 45	10. IF UNDER 1 YEAR Months 4 Days 7 Hours 19 Min. 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Retail Industry		11. BIRTHPLACE (State or foreign country) Washington D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Meunier				14. MOTHER'S M A D E N NAME Genevieve Dykes			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO		17. INFORMANT Katheryn R. Meunier Address Same As # 2			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart Failure DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost						INTERVAL BETWEEN ONSET AND DEATH over 2 yrs.	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 1B)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> hot While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that took charge of the remains described above held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe M.D., Riverdale, Maryland				22. DATE SIGNED 4-8-67			
EXAMINER'S NAME (Type) John Kehoe M.D., Riverdale, Maryland				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/11/67		23c. NAME OF CEMETERY OR CREMATORY Washington National		23d. LOCATION (City or Town) (County) (State) Prince Georges, Maryland	
24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home 4308 Suitland Road, Suitland, Maryland				25a. REC'D BY REGISTRAR APR 12 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

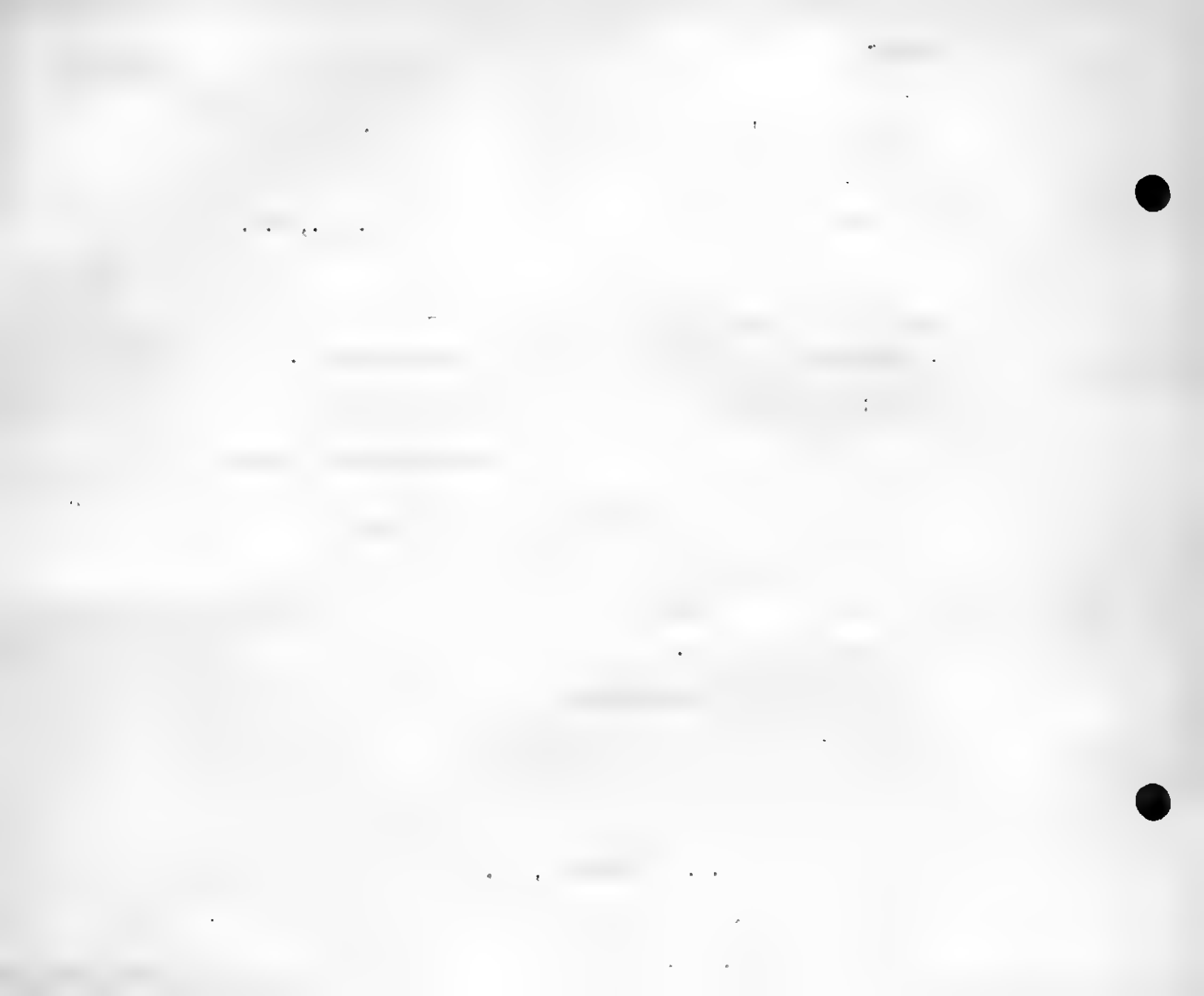
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



73

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
05672						MEDICAL EXAMINER'S CERTIFICATE OF DEATH						05672	
1 PLACE OF DEATH a COUNTY Prince George's MARYLAND						2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE D.C. b COUNTY							
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Riverdale				c LENGTH OF STAY IN 1b 7 days		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington							
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Ieland Memorial Hospital						d STREET ADDRESS 2020 32nd. St., S.E.						e RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Mamie B Meyer						4 DATE OF DEATH Month 4 Day 22 Year 19 67							
5 SEX Female		6 COLOR OR RACE White		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH 1-18-1878		9 AGE (in years lost birthday) yrs 89		10 UNDER 1 YEAR Months 12 Days 19 Hours 67 Min		11 UNDER 24 HRS Months 12 Days 19 Hours 67 Min	
10a U.S.A. OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b KIND OF BUSINESS OR INDUSTRY at home		11 BIRTHPLACE (State or foreign country) Washington, D.C.				12 CITIZEN OF WHAT COUNTRY? U.S.A.			
13 FATHER'S NAME William H Brewer						14 MOTHER'S MAIDEN NAME Mary Ward							
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16 SOCIAL SECURITY NO		17 INFORMANT Harryett Crump, same as 2.D						Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) (c)												INTERVAL BETWEEN ONSET AND DEATH minutes days	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture of left hip.												19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B) Fell at home									
20c TIME OF INJURY Month Day Year Hour:am 10:40pm 4-15- 1967				20d INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>				20e PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) Home		20f (City or town) (County) (State) same as #2			
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE John Kehoe, M.D.				EXAMINER'S NAME (Type) John Kehoe, M.D.				22. DATE SIGNED 4-24-67					
23a BURIAL CREMATION REMOVAL (Specify) Burial				23b DATE THEREOF 4.26.67		23c NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery				23d LOCATION (City or town) (County) (State) Suitland, Maryland			
24 FUNERAL DIRECTOR Lee Funeral Home, 300.4th st N E						25a RECD BY REGISTRAR APR 27 1967		25b REGISTRAR'S SIGNATURE Charles Judge					



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05673

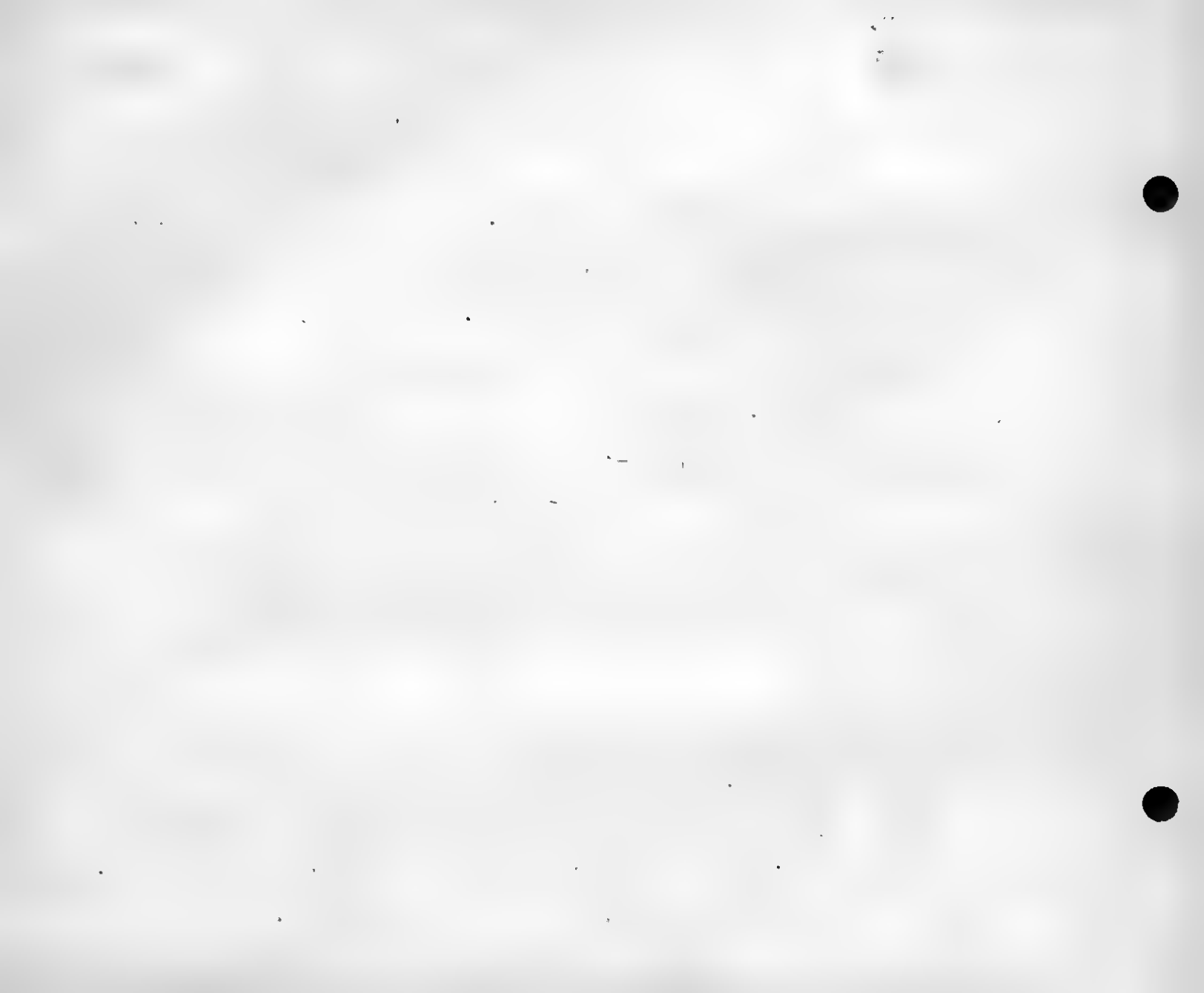
CERTIFICATE OF DEATH

05673

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Prince George MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution an. Residence before admission) a. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. LENGTH OF STAY IN 1b 19 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Home, 5805 Queens Chapel Rd.		d. STREET ADDRESS 913 Jackson Street, N.E.	
3. NAME OF DECEASED (Type or print) First Marguerite C. Middle Last Moore		4. DATE OF DEATH Month April Day 16 Year 19 67	
5 SEX female	6 COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Aug. 23, 1891
9 AGE (In years last birthday) yrs. 75		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Legal work	
10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State or foreign country) Philadelphia, Pa.	
12 CITIZEN OF WHAT COUNTRY? United States		13. FATHER'S NAME Richard F. Moore	
14 MOTHER'S MAIDEN NAME Mary A. Rodgers		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) unknown	
16. SOCIAL SECURITY NO 578-62-2462		17. INFORMANT Address Sacred Heart Home, Hyattsville, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u> DUE TO (b) <u>Peel</u> DUE TO (c) <u>Peel</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Pneumonia</u>			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>Dec 12</u> , 19 <u>66</u> , to <u>April 16</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>April 16</u> , 19 <u>67</u> , and that death occurred at <u>7:45 P.M.</u> from causes and on the date stated above.	
22a. SIGNATURE <u>John F. Brennan Jr.</u> M.D.		22b. DATE SIGNED <u>April 16, 1967</u>	
22c. PHYSICIAN'S NAME (Type) John F. Brennan, Jr. M.D.		22d. ADDRESS 1034 Perry St., Washington, D.C. 20017	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/19/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		23d. LOCATION (City or town) (County) (State) <u>Wash., D.C.</u>	
24 FUNERAL DIRECTOR <u>Nalley's Funeral Home Inc.</u>		25a. REC'D BY REGISTRAR <u>APR 20 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



CERTIFICATE OF DEATH

05674

05674

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE CO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>VA.</u> b. COUNTY <u>FAUQUIER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u>		c. LENGTH OF STAY IN 1b <u>9 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WARRENTON</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CARROLL MANOR 4922 LASALLE RD</u>				d. STREET ADDRESS <u>HIE WINCHESTER ST.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>GERALDINE L MORSE</u>				4. DATE OF DEATH Month <u>APRIL</u> Day <u>9</u> Year <u>1967</u>			
5. SEX <u>FEM.</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-28-1886</u>	9. AGE (in years last birthday) <u>80</u> yrs.	10. IF UNDER 1 YEAR Months <u>8</u> Days <u>11</u>	11. IF UNDER 24 HRS Hours <u>8</u> Min. <u>11</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>ST. CLOUD, MINN.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Everett H. Morse</u>				14. MOTHER'S MAIDEN NAME <u>Evelyn C. Corrigan</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Schistine Carroll Manor</u>			
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>4x00</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>4-5 days</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Parglogia</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <u>4/1</u> , 19 <u>67</u> , to <u>4/8</u> , 19 <u>67</u> , that (1) (we) last saw the deceased alive on <u>4/8</u> , 19 <u>67</u> , and that death occurred at <u>5 p</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>John W Winkler Jr</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4/8/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN W WINKLER JR</u>				22d. ADDRESS <u>5800 10th St Hyattsville Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>4-11-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Warrenton Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Warrenton VA.</u>	
24. FUNERAL DIRECTOR <u>Let Funeral Home</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

05675

CERTIFICATE OF DEATH

05675

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, (pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a COUNTY <u>Prince George</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>2345 Bellevue Ave - Md - P. George</u> b. COUNTY <u>Chesley</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANHAM</u>		c LENGTH OF STAY IN 1b	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Magnolia Gardens Nursing Home</u>		d STREET ADDRESS <u>2345 Bellevue Ave</u>	
3 NAME OF DECEASED (Type or print) <u>CLARENCE Lee Moyer</u>		4. DATE OF DEATH <u>April 28 1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>July 19, 1881</u>
9 AGE (in years last birthday) <u>85</u> yrs		10 IF UNDER 1 year Months Days Hours Min	
10a USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Postal Employee</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>	
11 BIRTHPLACE (County & State or foreign country) <u>Virginia</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S. A</u>	
13. FATHER'S NAME <u>JAMES Moyer</u>		14. MOTHER'S MAIDEN NAME <u>----</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>231-22-9382</u>	
17. INFORMANT <u>Nursing home records</u>		Address <u>Same as #1</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Heart Failure</u> DUE TO <u>Arteriosclerotic Heart Disease</u> (b) <u>1 year</u> DUE TO <u>1 year</u> (c) <u>1 year</u>			INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>9/26, 1966</u> to <u>4/28, 1967</u> , that (I) (we) last saw the deceased alive on <u>4/28, 1967</u> , and that death occurred at <u>3:30 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Leon R. Levitsky</u>		22b. DATE SIGNED <u>4/28/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Leon R. Levitsky M.D.</u>		22d. ADDRESS <u>3408 Rhode Island Ave, Mt. Knievel, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>5/1/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Leesburg Va.</u>
24. FUNERAL DIRECTOR <u>Francis Gasch's Sons</u>		25a. REC'D BY REGISTRAR <u>MAY 2 1967</u>	
ADDRESS <u>Hyattsville, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05676

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05676

1 PLACE OF DEATH a COUNTY Prince George's MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b COUNTY Prince George's			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Camp Springs			c LENGTH OF STAY IN 1b 24 hours		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brandywine		
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Andrews Air Force Base Hospital				d STREET ADDRESS 6-14 Cedarville Trailer Ct.		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Donald D. Mulcahy				4 DATE OF DEATH Month April Day 30 Year 19 67			
5 SEX male		6 COLOR OR RACE white		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH 11 Feb. 1935	
9 AGE (In years last birthday) 32 yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MM1 SAILOR		10b KIND OF BUSINESS OR INDUSTRY U.S. NAVY		11. BIRTHPLACE (State or foreign country) WISCONSIN	
12. CITIZEN OF WHAT COUNTRY? USA				13 FATHER'S NAME RAYMOND STEVEN MULCAHY			
14 MOTHER'S MAIDEN NAME IRENE HANNAH DOLSON				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates at service) YES			
16. SOCIAL SECURITY NO 389-32-6231		17 INFORMANT Address VERDA N. MULCAHY 2 D					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Laceration of brain DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Multiple skull fractures DUE TO (c) Trauma - motorcycle accident							INTERVAL BETWEEN ONSET AND DEATH 24 hours 24 hours 24 hours
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 18.) Driver of motorcycle which skidded and overturned.				
20c TIME OF INJURY Month, Day, Year Hour a.m. 10:30am 4-29-67 19			20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e PLACE OF INJURY (Home, farm factory, street, office, highway) Cedarville Rd. 1 1/2 miles from Brandywine		20f (City or town) (County) (State) see
21 I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							22. DATE SIGNED 4-30-67
ACTUAL SIGNATURE John Kehoe			EXAMINER'S NAME (Type) John Kehoe, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Riverdale, Md.		
23a BURIAL INFORMATION Rite BURIAL		23b DATE THEREOF 5-6-1967		23c NAME OF CEMETERY OR CREMATORY MEMORY GARDENS		23d LOCATION (City or Town) (County) (State) CONCORD CALIF	
24 FUNERAL DIRECTOR W. H. Chambers Co		24b ADDRESS 1400 Chapin St NW, Wash. D.C.		25a REC'D BY REG STRAR MAY 4 1967		25b REG STRAR'S SIGNATURE J. Charles Judge	

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

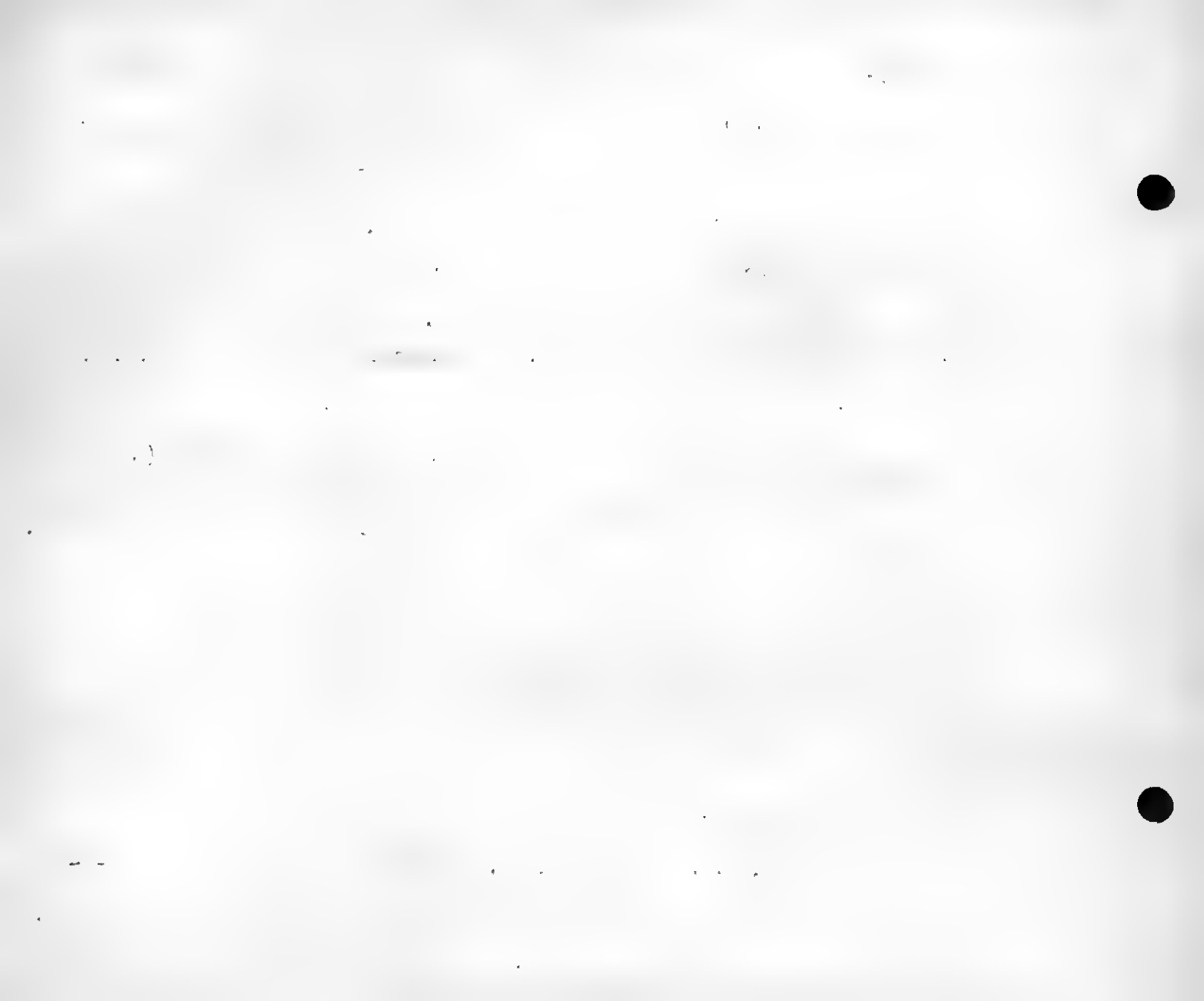
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05677

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05677

1 PLACE OF DEATH a. COUNTY Prince George's		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital		e. STREET ADDRESS 5408 40th. Avenue	
3. NAME OF DECEASED (Type or print) Robert		4. DATE OF DEATH Month 4 Day 2 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4 Oct. 1896
9. AGE (In years lost birthday) 70 yrs		10. USUAL OCCUPATION (Give kind of work done in most of last 12 months) Ret. Sales Manager	
11. KIND OF BUSINESS OR INDUSTRY Automobile Co.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert P. Murphy		14. MOTHER'S MAIDEN NAME Sallie A. Gale	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO WW 1 281 12 9075	
17. INFORMANT Rose D. Murphy Same as #2 (wife)		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure DUE TO Arteriosclerotic heart disease (b) _____ DUE TO _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH minutes over 1 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED 4-3-67	
ACTUAL SIGNATURE John Kehoe M.D. EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, City, town or county)	
23a. BURIAL (CREMATION) Burial		23b. DATE THEREOF 4/6/67	
23c. NAME OF CEMETERY OR CREMATORY Alexandria National		23d. LOCATION (City or Town) (County) (State) Alexandria Va.	
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR APR 5 1967	
ADDRESS		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05678

05678

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince Georges		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b 2 hrs. 40 min.		2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville,	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital						d. STREET ADDRESS 5816 Maryhurst Drive					
3. NAME OF DECEASED (Type or print) First Mary Middle Esther Last Myers						4. DATE OF DEATH Month April Day 16 Year 19 67					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-15-95		9. AGE (In years last birthday) 72 yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) secretary				10b. KIND OF BUSINESS OR INDUSTRY government		11. BIRTHPLACE (County & State, or foreign country) Mo.				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Corrigan						14. MOTHER'S MAIDEN NAME Blanche Cunningham					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO 577-50-1173		17. INFORMANT JOHN H. MYERS Address 2008 JASMINE RD. BALTIMORE, MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute Coronary occlusion 4201 DUE TO Coronary Artery Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio Sclerotic Heart Disease (c) Arterio Sclerotic Heart Disease										INTERVAL BETWEEN ONSET AND DEATH 12 mo 8 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from April 16, 1967 to April 16, 1967 , that (I) (we) lost saw the deceased alive on April 16, 1967 and that death occurred at 7:10 M, from causes and on the date stated above.											
22a. SIGNATURE L W Malin M.D.										22b. DATE SIGNED 4/16/67	
22c. PHYSICIAN'S NAME (Type) L W MALIN, M.D.										22d. ADDRESS Kinensdale, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4-19-67		23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEM				23d. LOCATION (City or Town) (County) (State) BLADENBURG MD			
24. FUNERAL DIRECTOR W.W. Chambers & Co						ADDRESS Riverdale, Md		25a. REC'D BY REGISTRAR DATE APR 20 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
05679 CERTIFICATE OF DEATH 05679									
1. PLACE OF DEATH a. COUNTY Prince George County MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Greenbelt			c. LENGTH OF STAY IN lb		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Greenbelt			d. STREET ADDRESS 44 K Ridge Road	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 44 K Ridge Road					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last MARY ETTA O'MALLEY					4. DATE OF DEATH Month Day Year April 24 1967				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 3, 1903		9. AGE (in years last birthday) 63 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife-Waitress			10b. KIND OF BUSINESS OR INDUSTRY At Home			11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James T. Sturgis					14. MOTHER'S MAIDEN NAME Oliver K. Griffin				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No None			16. SOCIAL SECURITY NO. Unknown		15. INFORMANT Joseph M. O'Malley			Address 2624 Conn. Md. Ave. Columbia Pk.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive & arteriosclerotic heart disease with failure. Diabetes mellitus DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Obesity								INTERVAL BETWEEN ONSET AND DEATH few minutes years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Dec 1, 1965 to April 23, 1967 , that (I) (we) last saw the deceased alive on 4-19-1967 and that death occurred at 12:00 M. from the causes and on the date stated above.									
22a. SIGNATURE John R. Spencer					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 4-24-67	
22c. PHYSICIAN'S NAME (Type) JOHN R. SPENCER, M.D.					22d. ADDRESS BURTONSVILLE, MD.				
23a. BURIAL, CREMATION, OR OTHER DISPOSAL Burial			23b. DATE THEREOF Apr. 26, 1967		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) (State) Arlington, Virginia		
24. FUNERAL DIRECTOR W. W. CHAMBERS CO., Riverdale, Md.					25a. REC'D BY REGISTRAR APR 27 1967		25b. REGISTRAR'S SIGNATURE Chambers, Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

05681

CERTIFICATE OF DEATH

05681

1 PLACE OF DEATH a COUNTY PRINCE GEORGE'S MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL ✓	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE		c LENGTH OF STAY IN 1b 10 Hrs 32 Min	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LOTHIAN
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF HOSPITAL ANDREWS		d. STREET ADDRESS PME, LOT 135A	
3 NAME OF DECEASED (Type or print) First Middle Last JOSEPH KEITH PARKER		4 DATE OF DEATH Month Day Year APRIL 3 1967	
5 SEX MALE	6 COLOR OR RACE CAU	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 3 APR 67
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY NA	9. AGE (In years last birthday) yrs 10 32
11. BIRTHPLACE (County & State or foreign country) ANDREWS AFB, COUNTY GEORGE		12. CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME ABRAHAM (NMN) PARKER		14. MOTHER'S MAIDEN NAME PATTI ARLENE LA POINTE	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO	16 SOCIAL SECURITY NO. NA	17 INFORMANT FATHER #, SAME AS # 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO CARDIORESPIRATORY FAILURE DUE TO HYALINE MEMBRANE DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)			INTERVAL BETWEEN ONSET AND DEATH 10 HRS 10 HRS
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 3 APRIL 1967 , to 3 APRIL 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 3 APRIL 1967 , and that death occurred at 0700PM , from causes and on the date stated above.			
22a. SIGNATURE <i>Roger E. Spitzer, MD</i>		22b. DATE SIGNED 3 APRIL 1967	
22c. PHYSICIAN'S NAME (Type) ROGER E. SPITZER, CAPT, USAF, MC		22d. ADDRESS USAF HOSPITAL ANDREWS, ANDREWS AFB, WASH D.C. 20331	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF April 6-67	23c. NAME OF CEMETERY OR CREMATORY Steep Falls Cemetery, Inc.	23d. LOCATION (City or Town) (County) (State) Steep Falls, Maine
24. FUNERAL DIRECTOR <i>Simmons Bros.</i> Simmons Bros., 1661-Gd. Hope Rd. SE. Wash., DC		25a. REC'D BY REGISTRAR APR 6 1967	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
05682											
1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES CO MD</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>LANDOVER HILLS MD</u> c. LENGTH OF STAY IN (b) <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince Georges General Hospital</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>PRINCE GEORGES</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Landover Hills</u> d. STREET ADDRESS <u>6814 - Reister St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>WILLIAM P. PARRISH</u> First Middle Last 4. DATE OF DEATH <u>APRIL 14 1967</u> Month Day Year						5. SEX <u>MALE</u> 6. COLOR OR RACE <u>CAUCAS.</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Jan 3 1924</u> Month Day Year 9. AGE (in years last birthday) <u>43</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>U S Government</u> 11. BIRTHPLACE (County & State, or foreign country) <u>New York</u> 12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>						13. FATHER'S NAME <u>John W Parrish</u> 14. MOTHER'S MAIDEN NAME <u>May Prest</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> 16. SOCIAL SECURITY NO. <u>WW 11</u> 17. INFORMANT <u>Birdie Parrish Landover Hills, Md.</u> Address						18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARRHYTHMIA, FIBRILLATION</u> DUE TO (b) <u>MYOCARDIAL ISCHEMIA</u> DUE TO (c) <u>ATHEROSCLEROTIC HEART DISEASE</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CHRONIC BRONCHITIS</u>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH <u>ACUTE MORE THAN 5 YRS</u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)						21. I certify that (I) <u>James W. Harding</u> attended the deceased from <u>JULY 1963</u> to <u>APRIL 14 1967</u> that (I) <u>yes</u> saw the deceased alive on <u>APRIL 14 1967</u> , and that death occurred at <u>1 A.M.</u> from the causes and on the date stated above. 22a. SIGNATURE <u>James W. Harding, M.D.</u> 22b. DATE SIGNED <u>April 14, 1967</u> 22c. PHYSICIAN'S NAME (Type) <u>James W. Harding, M.D.</u> 22d. ADDRESS <u>7601 RIVERDALE RD, NEW CARROLLTON MD</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>April 17, 1967</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Ft Lincoln Cemetery</u> 23d. LOCATION (City, town or county) <u>Colmar Manor Pro Geo Md.</u> (State) <u>MD</u>						24. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u> ADDRESS <u>Hyattsville, Md.</u> 25a. REC'D BY REGISTRAR <u>APR 17 1967</u> DATE 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the baby papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any case within 72 hours after death.

VR A15 (4)
20 M 1/64

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05683

Item #11 infor. taken from birth cert.

CERTIFICATE OF DEATH

05683

1. PLACE OF DEATH a. COUNTY Prince Georges b. (CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS 7216-79th Ave.	
3. NAME OF DECEASED (Type or print) First Middle Last Baby Boy "A" Pasch		4. DATE OF DEATH Month Day Year April 12, 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 12, 1967
9. AGE (In years last birthday) n/a yrs		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min. 5 51	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Cheverly, Pr. Geo. Co.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Bruce E. Pasch		14. MOTHER'S MAIDEN NAME Catherine Ann Simone	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) pulmonary Atelectasis Bilat 7625 DUE TO (b) Prematurity 600 Gms DUE TO (c) last		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)	20f. (City or town) (County) (State)
21. I certify that 888 (this hospital) attended the deceased from April 12, 1967 , to April 12, 1967 , that (s) (we) lost the deceased alive on April 12, 1967 , and that death occurred at 7:24 AM , from causes and on the date stated above.			
22a. SIGNATURE Bernardo Alvarado, M. D.		22b. DATE SIGNED MAY 2 1967	
22c. PHYSICIAN'S NAME (Type) Bernardo Alvarado, M. D.		22d. ADDRESS Prince Georges General Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE THEREOF 4/29/67	23c. NAME OF CEMETERY OR CREMATORY Prince George's Gen. Hosp. Cheverly, PG Maryland	23d. LOCATION (City or town) (County) (State)
24. FUNERAL DIRECTOR Harry W. Penn, Jr., Admin., Cheverly, Maryland		25. REG. BY REGISTRAR Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
05684 Item #11 infor. taken from birth cert.									
CERTIFICATE OF DEATH									
05684									
1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN lb 1 hr 17 mins d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville, d. STREET ADDRESS 7216 - 79th Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last Baby Girl "B" Pasch					4. DATE OF DEATH Month Day Year April 12, 1967				
5 SEX Female		6 COLOR OR RACE White		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 12, 1967		9 AGE (In years last birthday) n/a yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		1 BIRTHPLACE (County & State, or foreign country) Cheverly, Pr. Geo. Co.			12 CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Bruce E. Pasch					14. MOTHER'S MAIDEN NAME Catherine Ann Simone				
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16 SOCIAL SECURITY NO.		17. INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atelelectasis Pul. Bilat 7625 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) Pro Maternity 500 Grams (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (he) (this hospital) attended the deceased from April 12, 1967 , to April 12, 1967 , that (he) (we) last saw the deceased alive on April 12, 1967 , and that death occurred at 2:52 PM , from causes and on the date stated above.									
22a. SIGNATURE Bernardo Alvarado, M. D.					22b. DATE SIGNED MAY 2 1967		22c. PHYSICIAN'S NAME (Type) Prince Georges General Hospital		
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 4/29/67		23c. NAME OF CEMETERY OR CREMATORY Prince George's Gen. Hosp.		23d. LOCATION (City or Town) (County) (State) Cheverly PG Maryland		24. FUNERAL DIRECTOR ADDRESS Harry W. Penn, Jr., Admin., Cheverly, Maryland	
25a. REC'D BY REGISTRAR MAY 2 1967					25b. REGISTRAR'S SIGNATURE J. Charles Judge				

FOR STATE
HEALTH-DEPT. M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If July delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1 67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05686

05686

1. PLACE OF DEATH a COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a STATE Maryland b COUNTY Prince George's	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c LENGTH OF STAY IN TB DOA	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d STREET ADDRESS 9222 Woodyard Rd.	
3. NAME OF DECEASED (Type or print) First Marvin Middle William Last Peters		4. DATE OF DEATH Month 4 Day 8 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5 August 1908
9. AGE (In years last birthday) yrs 58		10. IF UNDER 1 YEAR Months Days Hours Min 19 67	
11a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Construction		11b. KIND OF BUSINESS OR INDUSTRY West Va.	
12. BIRTHPLACE (State or foreign country) West Va.		13. CITIZEN OF WHAT COUNTRY U.S.A.	
14. FATHER'S NAME William Peters		15. MOTHER'S MAIDEN NAME Poland	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes		17. SOCIAL SECURITY NO. 12	
18. INFORMANT Hospit 1 records		Address	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Shock and hemorrhage Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost (b) Bilateral hemothorax and multiple fractures - (Right tibia and fibula, Left tibia and fibula) (c) Right Femur		INTERVAL BETWEEN ONSET AND DEATH MINUTE	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of Item B) Struck by car while crossing street	
20c. TIME OF INJURY Month, Day, Year Hour, am, pm 2:00 am 4-8 1967		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) Rt 5, at Alexandria Ferry Rd		20f. (City or town) (County) (State) P.G. Md.	
21. I certify that took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe, M.D., Riverdale		22. DATE SIGNED 4/8/67	
EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL CREMATION REMOVAL (Specify) Burial	23b. DATE THEREOF 4/11/67	23c. NAME OF CEMETERY OR CREMATORY Notts Chapel	23d. LOCATION (City or town, County, State) .. Va.
24. FUNERAL DIRECTOR Tyson Heeler Funeral Home-1331 Rockville Pike		25a. RECORD BY REGISTRAR APR 11 1967	
ADDRESS Rockville, Md.		25b. REGISTRAR'S SIGNATURE John Charles Judge	



05687

CERTIFICATE OF DEATH

05687

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN IT 28 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS 8406 Adelphi Road	
3. NAME OF DECEASED (Type or print) Edith S Peterson		4. DATE OF DEATH Month April Day 27 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10 Oct. 1901
9. AGE (In years last birthday) 65 yrs		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Mins 0	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank Kartlai		14. MOTHER'S MAIDEN NAME Sophia Westerlund	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO 578 46 2090T	
17. INFORMANT Norman E. Peterson Sr. Same as #2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of the head of the pancreas. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Feb 1 , 19 67 , to April 27 , 19 67 , that (I) (we) last saw the deceased alive on April 27 , 19 67 , and that death occurred at 1:30AM , from causes and on the date stated above.			
22a. SIGNATURE Aaron Deitz		22b. DATE SIGNED 4/27/67	
22c. PHYSICIAN'S NAME (Type) Aaron Deitz, M. D.		22d. ADDRESS Prince Georges Plaza, Hyattsville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4/29/67	23c. NAME OF CEMETERY OR CREMATORY George Washington	23d. LOCATION (City or Town) (County) (State) Hyattsville P.G. Md.
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR APR 28 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, at removal, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05688

CERTIFICATE OF DEATH

05688

1 PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale c. LENGTH OF STAY IN b 2 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Leland Memorial Hospital				2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Univeristy Park d. STREET ADDRESS 6521 40th Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Pauline Mary Phelan				4 DATE OF DEATH Month April Day 20 Year 19 67			
5. SEX Female		6. COLOR OR RACE White		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-27-07	
9 AGE (In years last birthday) 59 yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Maryland	
12 CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Samuel L. Reynolds				14. MOTHER'S MAIDEN NAME Mary M. Pendergast	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO none		17 INFORMANT daughter in law/medical record Address			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE ACUTE DUE TO Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 3 DAYS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from 4-18-67 , to 4-20 , 19 67 , that (I) (we) last saw the deceased alive on 4-20 19 67 , and that death occurred at 10 A.M. , from causes and on the date stated above.							
22a. SIGNATURE C.J. Houmann				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4-20-67	
22c. PHYSICIAN'S NAME (Type) C.J. Houmann, M. D.				22d. ADDRESS 4404 Queensbury Road, Riverdale, Md.			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/22/67		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION (City or Town) (County) (State) Silver Spring Montg. Md.	
24 FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Maryland				25a REC'D BY REGISTRAR APR 24 1967		25b REGISTRAR'S SIGNATURE [Signature]	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05683

CERTIFICATE OF DEATH

05689

1. PLACE OF DEATH a. COUNTY P. G. Riverdale, MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY P.G.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale, Md.				c. LENGTH OF STAY IN 1b 1 Day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville, Md.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Leland Hospital				d. STREET ADDRESS 4827 Lexington Ave.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Luella Middle M Last Pierce				4. DATE OF DEATH Month 4- Day 5 Year 19 67			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH 6-13-96		9. AGE (In years last birthday) 70 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY? Amer USA	
13. FATHER'S NAME Howard Springer,				14. MOTHER'S MAIDEN NAME Hattie Hurst			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO 187-01-8654		17. INFORMANT Address Eugene Leland Hospital, 4408 Queensbury Rd.,			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO Arterio-Sclerotic and Hypertensive Heart (b) Disease with Congestive Heart Failure DUE TO and Auricular Fibrillation (c) Diabetes Mellitus							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1956 , 19 4/5/67 to 4/5/67 , that (I) (we) last saw the deceased alive on 4/5/67 , and that death occurred at 11:30 p.m. from causes on and on the date stated above.							
22a. SIGNATURE <i>Robert C. Wingfield</i> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4-6-1967	
22c. PHYSICIAN'S NAME (Type) Robert C. Wingfield, M.D.				22d. ADDRESS 329 Prince George Street Laurel, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF April 9, 1967		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery,		23d. LOCATION (City or town) (County) (State) Washington, D.C.	
24. FUNERAL DIRECTOR ADDRESS Harold S. Wade, Laurel, Maryland				25a. REC'D BY REGISTRAR DATE APR 10 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



CERTIFICATE OF DEATH

05690

05690

<p>1. PLACE OF DEATH</p> <p>a. COUNTY <u>Prince Georges</u> MARYLAND</p> <p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u></p> <p>c. LENGTH OF STAY IN 1b <u>4 days</u></p> <p>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General</u></p>				<p>2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)</p> <p>a. STATE <u>MD</u> b. COUNTY <u>Prince Georges</u></p> <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u></p> <p>d. STREET ADDRESS <u>2807 63rd PL.</u></p> <p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>			
<p>3. NAME OF DECEASED (Type or print) <u>Peter (Pietro) PIZZA</u></p>		<p>4. DATE OF DEATH <u>April 1 1967</u></p>		<p>5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u></p>			
<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <u>12 JULY 1886</u></p>		<p>9. AGE (In years last birthday) <u>80 yrs.</u></p>			
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Grocer</u></p>		<p>10b. KIND OF BUSINESS OR INDUSTRY <u>GROCE</u></p>		<p>11. BIRTHPLACE (County & State, or foreign country) <u>ITALY</u></p>			
<p>13. FATHER'S NAME <u>Luigi Rizza</u></p>		<p>14. MOTHER'S MAIDEN NAME <u>Maria Tornelli</u></p>		<p>12. CITIZEN OF WHAT COUNTRY? <u>YES-USA</u></p>			
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or town, (If yes give year or dates of service)) <u>NO</u></p>		<p>16. SOCIAL SECURITY NO. <u>577-48-4255A</u></p>		<p>17. INFORMANT <u>KATHRYN SOIB-PICCOLI</u></p>			
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u></p> <p>Conditions, if any, which gave rise to immediate cause (b) <u>Coronary Thrombosis, acute</u></p> <p>(a), stating the underlying cause last, (c) <u>Generalized Arteriosclerosis</u></p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</p>							
<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>							
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p> <p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)</p> <p>20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19</p> <p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></p> <p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p> <p>20f. (City or town) (County) (State)</p>							
<p>21. I certify that (I) (this hospital) attended the deceased from <u>3/29</u>, 1967 to <u>4/1</u>, 1967 that (I) (we) last saw the deceased alive on <u>4/1</u>, 1967, and that death occurred at <u>2:55</u> M, from the causes and on the date stated above.</p>							
<p>22a. SIGNATURE <u>Norman A. Comer</u></p>		<p>22b. DATE SIGNED <u>4/1/67</u></p>		<p>22c. PHYSICIAN'S NAME (Type) <u>Norman A. Comer</u></p>			
<p>22d. ADDRESS <u>3503 Penny St Mt Rainier MD</u></p>		<p>22e. REC'D BY REGISTRAR <u>APR 4 1967</u></p>					
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u></p>		<p>23b. DATE THEREOF <u>4 April 1967</u></p>		<p>23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u></p>			
<p>23d. LOCATION (City, town or county) <u>Wash., D.C.</u></p>		<p>23e. REGISTRAR'S SIGNATURE <u>Charles J. J...</u></p>					
<p>24. FUNERAL DIRECTOR'S SIGNATURE <u>RINALDI FUNERAL HOME</u></p>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate is retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05691

CERTIFICATE OF DEATH

05691

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN TB 1 day	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mitchellville			161
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				d. STREET ADDRESS Box 6		e. RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Estelle G. Gibson Plotts				4. DATE OF DEATH Month Day Year April 6 1967			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/11/05		9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Robert V. Gibson, Sr.				14. MOTHER'S MAIDEN NAME Iola Pearl Lane			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO -----		17. INFORMANT Address William S. Plotts-Box 6 Mitchellville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 1962 to 4/6 , 1967, that (I) (we) last saw the deceased alive on 4/6 , 1967, and that death occurred at 10:15M , from causes and on the date stated above.							
22a. SIGNATURE Dr. A. Clark Holmes				22b. DATE SIGNED 4/7/67		22c. PHYSICIAN'S NAME (Type) Dr. A. Clark Holmes	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/10/67		23c. NAME OF CEMETERY OR CREMATORY Washington Nat'l Cem.		23d. LOCATION (City or Town) (County) (State) Suitland Md.	
24. FUNERAL DIRECTOR ADDRESS Ritchie Bros. Upper Marlboro, Md.				25a. REC'D BY REGISTRAR DATE APR 12 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



05692

05692

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

Items 10821 Film 339
6-19-67
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05693

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05693

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b DOA d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville d. STREET ADDRESS 5716 Chillum Heights Drive. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Daniel Powell, Jr.				4. DATE OF DEATH Month 4 Day 18 Year 1967			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 23 Sept. 1931	
9. AGE (In years last birthday) 35 yrs		10a. US. AL. OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY Restaurant		11. BIRTHPLACE (State or foreign country) West Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Daniel Powell Sr.				14. MOTHER'S MAIDEN NAME Alice M. Stanton	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes Korean		16. SOC. AL. SEC. NO. 579 38 2929		17. INFORMANT Mrs. Paula A. Jensen Same as #2 (sister)			
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration of gastric contents DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> hot While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above held an Autopsy <input checked="" type="checkbox"/> . Inspect on <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe, M.D. Riverdale, Md.				22. DATE SIGNED 4-19-67			
23a. BURIAL, CREMATION, REMOVAL Specify Burial		23b. DATE THEREOF 4/21/67		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d. LOCATION (City or town) (County) (State) Colmar Manor, P.G. Md.	
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.				25a. REC'D BY REGISTRAR APR 24 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

Item 9 2388 5/1/67 kk

05694

CERTIFICATE OF DEATH

05694

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 9 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 8601 Manchester Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Alice B. Prendable				4. DATE OF DEATH Month Day Year April 24, 19 67			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1889-7-22	
9. AGE (In years last birthday) 78 7 yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) West Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Andrew Huffman		14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 579 18 3902	
16. SOCIAL SECURITY NO. 579 18 3902		17. INFORMANT Frances Darwin Silver Spring, Md.		18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Pulmonary Embolism, bilateral DUE TO (b) DUE TO (c) 465 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) this hospital attended the deceased from April 15, 1967 , to April 24, 1967 , that (I) we saw the deceased alive on April 24, 1967 , and that death occurred at 2:45 PM , from causes and on the date stated above.							
22a. SIGNATURE B. Rosenberg				22b. DATE SIGNED April 25, 1967		22c. PHYSICIAN'S NAME (Type) Barry Rosenberg, M.D.	
22d. ADDRESS 6501 Landover Rd. Cheverly, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-27-67		23c. NAME OF CEMETERY OR CREMATORY Arlington Natl. Cem.		23d. LOCATION (City or Town) (County) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR Lee Funeral Home				25a. REC'D BY REGISTRAR Washington, D.C.		25b. REGISTRAR'S SIGNATURE MAY 1 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05695

CERTIFICATE OF DEATH

05695

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b 15 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Leland Memorial Hospital				d. STREET ADDRESS 4708 Sheridan St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Jackson Middle L. Last Price				4. DATE OF DEATH Month April Day 20 Year 1967			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-11-00	9. AGE (In years last birthday) 67 yrs	IF UNDER 1 YEAR Months 67 Days 67 Hours 67 Min 67		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Agent Insurance Co.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Agent Insurance Co.			10b. KIND OF BUSINESS OR INDUSTRY Insurance Co.		11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Robert H. Price				14. MOTHER'S MAIDEN NAME Emma E. Foster			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO 577 10 0723		17. INFORMANT son/medical record Address Riverdale			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Pulmonary Embolus 466X DUE TO Thrombosis of left leg Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Thrombosis of left leg (c) Thrombosis of left leg							INTERVAL BETWEEN ONSET AND DEATH 5 Mon. 5+ days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4-5-1967 to 4-20-1967 , that (I) (we) last saw the deceased alive on 4-20-1967 , and that death occurred at 11:45 AM , from causes and on the date stated above.							
22a. SIGNATURE C. J. Houmann				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4-20-67	
22c. PHYSICIAN'S NAME (Type) C. J. HOUMANN				22d. ADDRESS RIVERDALE MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/22/67		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d. LOCATION (City or Town) (County) (State) Colmar Manor P. G. Md.	
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Maryland				25a. REC'D BY REGISTRAR APR 24 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

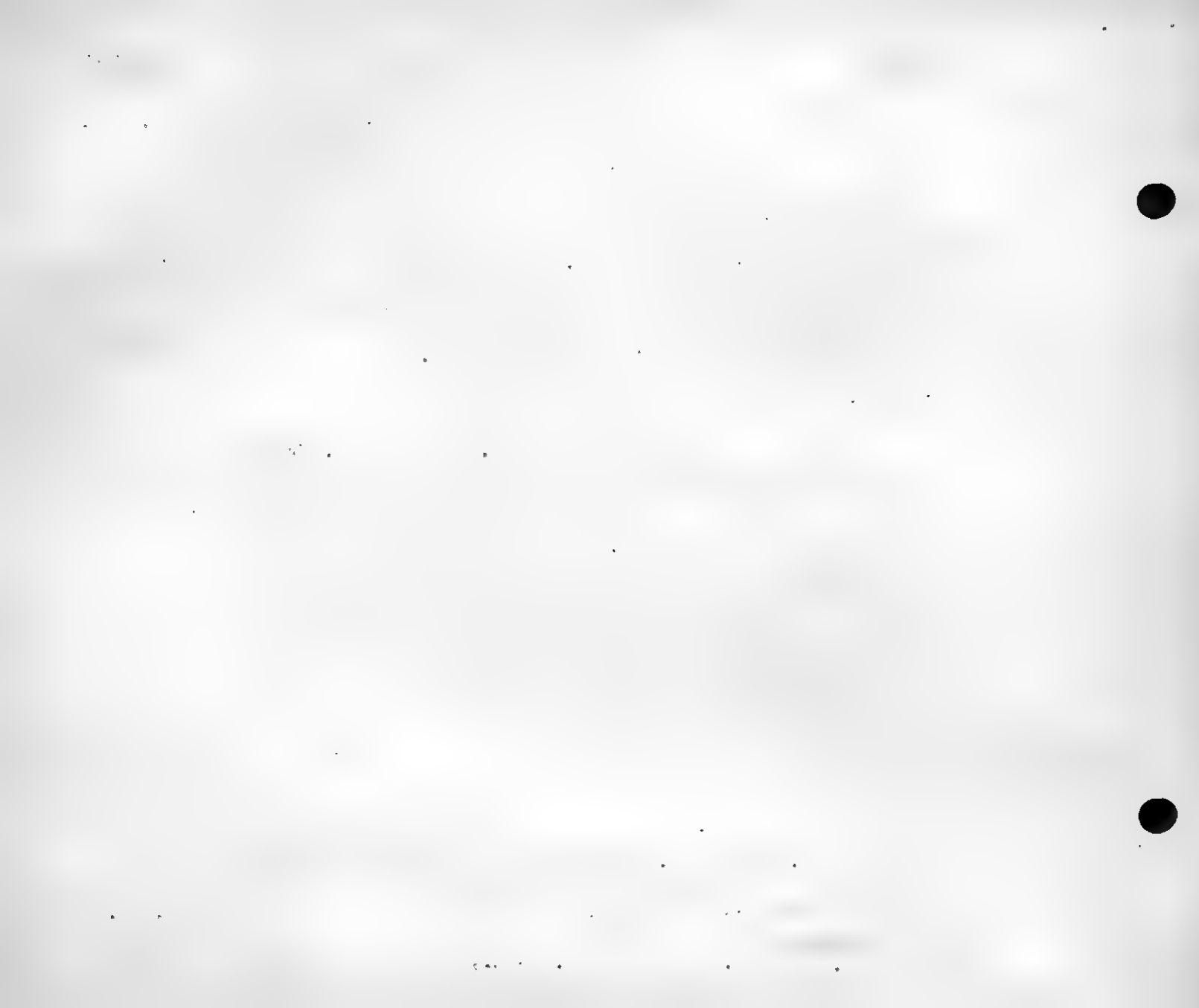
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05696

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05696

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Clinton		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Clinton	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Juliette Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle M. Last PRYDE		4. DATE OF DEATH Month April Day 12th Year 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 31-1904
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Principle-Surrattsville Senior High		10b. KIND OF BUSINESS OR INDUSTRY School	
11. BIRTHPLACE (County & State, or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Pryde		14. MOTHER'S MAIDEN NAME Agnes Mc Multy	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Elizabeth A. Pryde (Wife)		Address Same # 2 as	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 4/20/67 DUE TO (b) <u>Smoked Cigs and Remy Alcohol</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH 1 Day			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from 4-16, 1967, to 4-12, 1967 that (1) (we) last saw the deceased alive on 4-10, 1967, and that death occurred at 6:15 AM, from the causes and on the date stated above.			
22a. SIGNATURE <u>Richard H. Dobson</u>		22b. DATE SIGNED April 12-1967	
22c. PHYSICIAN'S NAME (Type) Dr. Richard H. Dobson		22d. ADDRESS Brandywine, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 15-67	
23c. NAME OF CEMETERY OR CREMATORY Plum Creek Cemetery		23d. LOCATION (City, town or county) (State) New Kensington, Pa.	
24. FUNERAL DIRECTOR <u>Simmons Bros.</u>		25a. REC'D BY REGISTRAR	
ADDRESS Simmons Bros. 1661- Gd. Hope Road Se. Wash., DC		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or reinterment and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
05697		05697									
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Riverdale				c. LENGTH OF STAY IN 1b 2 days		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hyattsville					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Eugene Leland Memorial Hospital						d. STREET ADDRESS 5731 29th Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Marie			Middle Purcell			Last Purcell			4. DATE OF DEATH Month 4 Day 15 Year 1967		
5. SEX Fem.		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-3-82		9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) England			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME -- Potts						14. MOTHER'S MAIDEN NAME --					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no				16. SOCIAL SECURITY NO. 215-50-0126		17. INFORMANT Hospital Admission Record Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RUPTURED ABDOMINAL AORTIC ANEURYSM 451X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 4-13, 1967, to 4-15, 1967, that (I) (we) last saw the deceased alive on 4-14, 1967, and that death occurred at 4:50 A.M. from the causes and on the date stated above.											
22a. SIGNATURE C.J. Houmann						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 4-15-67		
22c. PHYSICIAN'S NAME (Type) C.J. HOUMANN						22d. ADDRESS RIVERDALE MD					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 18, 1967		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery			23d. LOCATION (City, town or county) (State) Colmar Manor Pro Geo Md.				
24. FUNERAL DIRECTOR F. Gasch's Sons						ADDRESS Hyattsville, Md.			25a. REC'D BY REGISTRAR APR 18 1967		
						25b. REGISTRAR'S SIGNATURE Charles Judge					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please ~~insert~~ carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05698

CERTIFICATE OF DEATH

05698

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D O A	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BOWIE
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS 3500 MOYLAN DRIVE	
3. NAME OF DECEASED (Type or print) First FLORENCE Middle BOUCK Last REED		4. DATE OF DEATH Month APRIL Day 5 Year 1967	
5. SEX FEMALE	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/3/1892
9. AGE (In years last birthday) 74 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) SOUTH DAKOTA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME CYRUS BOUCK		14. MOTHER'S MAIDEN NAME IDA HOYT	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT PAULINE SCHEUFLE		Address SAME AS # 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 41201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELLITUS		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from NOV , 1966, to APRIL , 1967, that (I) (we) lost saw the deceased alive on APRIL 5 , 1967, and that death occurred at 10 30 PM , from causes and on the date stated above.			
22a. SIGNATURE Norman K Bohrer		22b. DATE SIGNED April 6, 1967	
22c. PHYSICIAN'S NAME (Type) Dr. Norman K. Bohrer		22d. ADDRESS 3231 Superior Lane, Bowie, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4/10/67	
23c. NAME OF CEMETERY OR CREMATORY MOUND HILL CEMETERY		23d. LOCATION (City or Town) (County) (State) PARISHVILLE, NEW YORK	
24. FUNERAL DIRECTOR ROBERT E. WILHELM		25a. REC'D BY REGISTRAR APR 7 1967	
ADDRESS 4308 SUTLAND ROAD, SUTLAND, MARYLAND		25b. REGISTRAR'S SIGNATURE J. Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #7 Film #G23-1-22/67 pg

CERTIFICATE OF DEATH

05693

05699

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Res dence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 3 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS 6901 Riverdale Rd.	
3 NAME OF DECEASED (Type or print) MATILDA B. RENALDS		4. DATE OF DEATH Month April Day 1 Year 67	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Aug. 12, 1884
9. AGE (In years last birthday) yrs 82		10. IF UNDER 1 Year IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Nurse		10b. KIND OF BUSINESS OR INDUSTRY Hospital	
11 BIRTHPLACE (County & State, or foreign country) Warren Co, Virginia		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Casper L. Craig		14 MOTHER'S MAIDEN NAME Linda Triplett	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) no		16 SOCIAL SECURITY NO 220 54 1249	
17. INFORMANT Lauretta G. Rusk Same as #2 (daughter)		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY 4300 IMMEDIATE CAUSE (a) Cardiac arrest DUE TO (b) Arteriosclerotic heart disease DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		INTERVAL BETWEEN ONSET AND DEATH 1 hr May 1967	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3/26 , 19 67 , to 4/1 , 19 67 , that (I) (we) last saw the deceased alive on 4/1 , 19 67 , and that death occurred at 6:45 A.M. from causes and on the date stated above.			
22a. SIGNATURE Frederick H. Wilhelm		22b. DATE SIGNED 4/1/67	
22c. PHYSICIAN'S NAME (Type) Frederick H. Wilhelm, M.D.		22d. ADDRESS 6314 Landover Road, Landover, Md.	
23a. BURIAL, CREMATION, or other disposal (Specify) Burial		23b. DATE THEREOF 4/4/67	
23c. NAME OF CEMETERY OR CREMATORY Prospect Hill		23d. LOCATION (City or Town) (County) (State) Front Royal Va.	
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR APR 4 1967	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05700

CERTIFICATE OF DEATH

05700

1 PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN lb 18 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		2 USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE Maryland b. COUNTY Prince Georges Howard c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel - Rural d. STREET ADDRESS Box 210-B - Route #1 e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last Howard C. Rice		4 DATE OF DEATH Month Day Year April 18 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 20, 1891
9. AGE (In years last birthday) 76 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (County & State, or foreign country) Howard Co. Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Godfrey Rice		14. MOTHER'S MAIDEN NAME Augusta Phoebe	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO	
17. INFORMANT Howard C. Rice Jr. Laurel Md		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4201 DUE TO Acute myocardial infarction (b) Acute Coronary Thrombosis DUE TO (c) Severe Cardiovascular Arteriosclerotic Heart Disease		INTERVA. BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (as hospital) attended the deceased from March 31, 1967 , to April 18, 1967 , that (I) (we) last saw the deceased alive on April 18, 1967 , and that death occurred on 12-15 , from causes and on the date stated above.			
22a. SIGNATURE Klon B. Cameron		22b. DATE SIGNED April 18, 1967	
22c. PHYSICIAN'S NAME (Type) Don B. Cameron, M.D.		22d. ADDRESS 3503 Perry St., Mt. Rainier, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-21-67	
23c. NAME OF CEMETERY OR CREMATORY St. Johns		23d. LOCATION (City or Town) (County) (State) Pleasanton Md.	
24. FUNERAL DIRECTOR De Witt Donaldson		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE APR 27 1967	



05701

CERTIFICATE OF DEATH

05701

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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1 PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brandywine	
c. LENGTH OF STAY IN 1b 1 & 1/2 days		d. STREET ADDRESS 215 Rt. #3, Box XXXX	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last Dora Estelle Richards		4. DATE OF DEATH Month Day Year April 25, 1967	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 12/3/02
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min 12 20 45	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11 BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James T. Canter		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO. -----	
17. INFORMANT Benjamin E. Richards		Address Rt 3, Box 204-B Brandywine, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH 12 20 45	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive Vascular disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from April 23, 1967 to April 25, 1967 , that (I) (we) last saw the deceased alive on April 25, 1967 , and that death occurred at 11:25M , from causes and on the date stated above.			
22a. SIGNATURE Frederick H. Wilhelm		22b. DATE SIGNED 4/25/67	
22c. PHYSICIAN'S NAME (Type) Frederick H. Wilhelm, M.D.		22d. ADDRESS 6319 Landover Rd., Cheverly, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4/28/67	23c. NAME OF CEMETERY OR CREMATORY Brookfield Cemetery	23d. LOCATION (City or Town) (County) (State) Naylor Md.
24 FUNERAL DIRECTOR Ritchie Bros. Upper Marlboro, Md.		25a. REC'D BY REGISTRAR MAY 5 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 4 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours of death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05702

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05702

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY (a to b) 4 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George General Hospital		e. STREET ADDRESS Hyattsville	
3 NAME OF DECEASED (Type or print) Albert A Rogers		4 DATE OF DEATH Month Day Year 4 24 1967	
5 SEX male	6 COLOR OR RACE white	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 22 May 1912
9 AGE (In years lost birthday) 54 yrs	10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Construction
11 BIRTHPLACE (State or foreign country) Virginia		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Joseph Rogers		14 MOTHER'S MAIDEN NAME Irene Bowler	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) no		16 SOCIAL SECURITY NO. none	
17 INFORMANT Joseph Rogers Jr. Same as #2		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Laceration of brain DUE TO Fracture of skull (b) _____ DUE TO _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) Fell at home.	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 2:30pm 4-20-67		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) Home	
20f. (City or town) (County) (State) same as #2			
21 I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe, M.D.		22. DATE SIGNED 4-24-67	
EXAMINER'S NAME (Type) John Kehoe, M.D.		Address (Street city town or county) Riverdale, Md.	
23a. BURIAL, CREMATION, REMOVAL (specify) Burial		23b. DATE THEREOF 4/26/67	
23c. NAME OF CEMETERY OR CREMATORY Grace Cemetery		23d. LOCATION (City or Town) (County) (State) Rollins Fork Va.	
24 FUNERAL DIRECTOR Francis Gasch's Sons		ADDRESS Hyattsville, Md.	
25 REGISTRAR'S SIGNATURE Charles Judge		DATE APR 26 1967	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

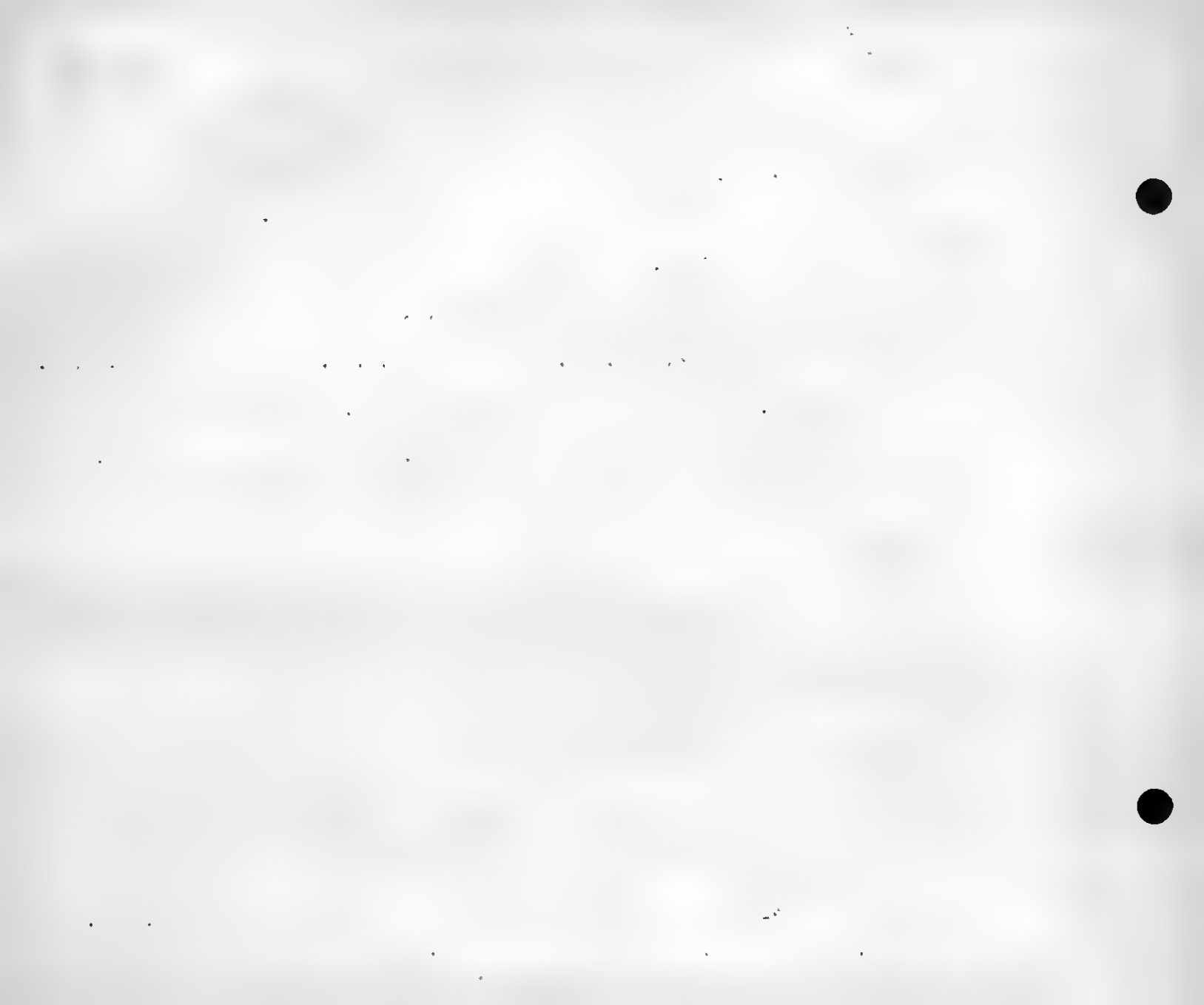
05703

CERTIFICATE OF DEATH

05703

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillcrest Hgts.				c. LENGTH OF STAY IN 1b Hillcrest Heights			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS 2902 Fairlawn St.			
3. NAME OF DECEASED (Type or print) Margaret E. Rollins				4. DATE OF DEATH Month April , Day 2 , Year 1967			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 2, 1914		9. AGE (in years last birthday) 53 yrs		10. IF UNDER 1 YEAR Months 1 Days 19 Hours 67 Min.
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employee School Board P. Geo. Co.			12. BIRTHPLACE (County & State, or foreign country) Wash. D. C.		13. CITIZENSHIP OF WHAT COUNTRY? U. S. A.		
14. FATHER'S NAME George F. Simpson			15. MOTHER'S MAIDEN NAME Margaret E. McWilliamson				
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no			17. SOCIAL SECURITY NO no		18. INFORMANT Wallace L. Rollins 2902 Fairlawn St.		
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Edema complicating stroke with metastasis DUE TO (b) stroke DUE TO (c) stroke							INTERVAL BETWEEN ONSET AND DEATH stroke
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 26-28 , 19 67 to April 2 , 19 67 , that (I) (we) last saw the deceased alive on 28 , 19 67 , and that death occurred at 3:30 PM , from causes and on the date stated above							
22a. SIGNATURE T. O'Donovan			M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED APR 6 1967		
22c. PHYSICIAN'S NAME (Type) T. O'DONOVAN			22d. ADDRESS 4005 Stan PRd SE.				
23a. BURIAL, (CREMATON, REMOVAL) (Specify) Burial		23b. DATE THEREOF 4-4-67		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION (City or Town) (County) (State) Suitland P. G. Md.	
24. FUNERAL DIRECTOR Robert E. Wilhelm			ADDRESS Fun Home 4308 Suitland Rd. Suitland, Md.		25a. REC'D BY REGISTRAR APR 6 1967		
					25b. REGISTRAR'S SIGNATURE Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and may event, within 72 hours after death.

Approval to sign certificate by Dr. Walters, coroner - J. Walters

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05704 CERTIFICATE OF DEATH 05704

1. PLACE OF DEATH a. COUNTY <i>Prince George's</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Pr. Geo.</i>	
b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) <i>Hyattsville</i>		c. LENGTH OF STAY IN 1b <i>2 yrs</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>3450 Toledo Terrace</i>		d. STREET ADDRESS <i>3450 Toledo Terrace</i>	
3. NAME OF DECEASED (Type or print) First Middle Last SR. <i>JAMES ARTHUR ROSENBERGER</i>		4. DATE OF DEATH Month Day Year <i>APRIL 6 1967</i>	
5. SEX <i>M.</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec. 21, 1874</i>
9. AGE (In years last birthday) <i>92</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Supervisor</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Railroad</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Sandusky County Ohio</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Perry F. Rosenburger</i>		14. MOTHER'S MAIDEN NAME <i>Clara Hummel</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <i>051 070158</i>	
17. INFORMANT Address <i>Mrs. Rella M. Rosenburger (same as #2)</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4201 Acute myocardial infarction</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic cardiovascular d.</i> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>5 min.</i> <i>years.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <i>Jan.</i> , 1965, to <i>Apr.</i> , 1967, that (2) (we) last saw the deceased alive on <i>Dec 2</i> 1966, and that death occurred at <i>7:30</i> AM, from the causes and on the date stated above.			
22a. SIGNATURE <i>James R. Coleman MD</i>		22b. DATE SIGNED <i>Apr 6, 1967</i>	
22c. PHYSICIAN'S NAME (Type) <i>JAMES R. COLEMAN</i>		22d. ADDRESS <i>9241 COLUMBIA BLVD SILVER SPRING Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <i>April 10, 1967</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Fort Lincoln Cemetery</i>	23d. LOCATION (City, town or county) (State) <i>Pr. Geo. Co. Maryland</i>
24. FUNERAL DIRECTOR <i>Arthur Walters, 254 Carroll Ave. NW. DC</i>		25a. REC'D BY REGISTRAR <i>100 1 10 1967</i>	
25b. REGISTRAR'S SIGNATURE <i>Arthur Walters</i>			

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
6M 1 67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05705

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05705

1 PLACE OF DEATH a COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE Maryland b COUNTY Prince George's	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Hyattsville	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 9533 Riggs Road		d STREET ADDRESS 9533 Riggs Road	
3 NAME OF DECEASED (Type or print) John Ross		4 DATE OF DEATH Month 4 Day 25 Year 19 67	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 16 Feb. 1883
9 AGE (In years last birthday) 84 yrs	IF UNDER 1 YEAR Months Days Hours Min.		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Coal Miner
10b KIND OF BUSINESS OR INDUSTRY Coal Mining		11 BIRTHPLACE (State or foreign country) Pennsylvania	
12 CITIZEN OF WHAT COUNTRY? U.S.A.		13 FATHER'S NAME ? Ross	
14 MOTHER'S MAIDEN NAME -----		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no	
16 SOCIAL SECURITY NO		17 INFORMANT Address Patrick Ross Same as #2 (son)	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Massive bilateral anthra silicosis 5231 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) And bilateral bronchopneumonia DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> . Inspec on <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John Kehoe</i> M.D.		22. DATE SIGNED 4-26-67	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		Address (Street, city, town, or county)	
23a BURIAL CREMATION, RESOLV (Specify) Burial	23b DATE THEREOF 4/28/67	23c NAME OF CEMETERY OR CREMATORY George Washington	23d LOCATION (City or Town) (County) (State) Hyattsville P.G. Md.
24 FUNERAL DIRECTOR ADDRESS Francis Gasch's Sons Hyattsville, Md.		25a REC'D BY REG-STRAR DATE APR 28 1967	
		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

CERTIFICATE OF DEATH

05706

05706

1 PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE'S</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution of residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLINTON, MARYLAND</u>		c. LENGTH OF STAY IN 1b <u>11419 Edmonstony AVE.</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Southern Maryland General Hospital</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>LEE</u> Middle <u>A</u> Last <u>ROSS</u>		4 DATE OF DEATH Month <u>4</u> Day <u>25</u> Year <u>1967</u>	
5 SEX <u>MALE</u>	6 COLOR OR RACE <u>NEGRO</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 AGE (In years, last birthday) <u>56</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Beltville Md</u>
13. FATHER'S NAME <u>Harry Ross</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Miller</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>Nine</u>		16. SOCIAL SECURITY NO <u>Agnes Ross Same as 2D</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> 1815 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) <u>CARDIO PULMONARY INSUFFICIENCY</u> DUE TO (c) <u>SCLERODERMA</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 MIN.</u> <u>4 MONTHS</u> <u>3 YEARS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>MYOCARDIAL INFARCTION</u>			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>N/A.</u>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B) <u>N/A.</u>	
20c TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>2/28/1967</u> to <u>4/25/1967</u> , that (I) <u>was</u> last saw the deceased alive on <u>4/25/1967</u> , and that death occurred at <u>11:15 AM</u> , from causes and on the date stated above			
22a. SIGNATURE <u>Alfred R. Lapin</u>		22b DATE SIGNED <u>4/25/67</u>	
22c PHYSICIAN'S NAME (Type) <u>ALFRED R. LAPIN</u>		22d ADDRESS <u>SO. MARYLAND GEN. HOSP. CLINTON, MD</u>	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF <u>4-29-67</u>	23c NAME OF CEMETERY OR CREMATORY <u>Queen's Chapel</u>	23d LOCATION (City or Town) (County) (State) <u>Murkbuk MD</u>
24 FUNERAL DIRECTOR <u>AS Washington & Sons 4925 Leano Ave NE</u>		25a REC'D BY REGISTRAR DATE <u>APR 27 1967</u>	25b REGISTRAR'S SIGNATURE <u>Charles Jones</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
05707 CERTIFICATE OF DEATH 05707									
1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BOWIE</u>					c. LENGTH OF STAY IN 1b <u>5 YEARS</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>12503 SCARLET LANE</u>					d. STREET ADDRESS <u>12503 SCARLET LANE</u>				
3. NAME OF DECEASED (Type or print) <u>LEONE N ROSS</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
5. SEX <u>FEMALE</u>					6. DATE OF DEATH <u>APRIL 9 1967</u>				
6. COLOR OR RACE <u>WHITE</u>					7. DATE OF BIRTH <u>JAN 17, 1915</u>				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. AGE (In years last birthday) <u>52</u> yrs.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>NAT. RIFLE ASSOC</u>				
13. FATHER'S NAME <u>WILLIAM NOBENS</u>					14. MOTHER'S MAIDEN NAME <u>ANNA MAE FISH</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>NO</u>					16. SOCIAL SECURITY NO. <u>474-14-5857</u>				
17. INFORMANT <u>HUSBAND - HARRY ROSS</u>					Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ANEMIA</u> DUE TO (b) <u>ACUTE MYELOGENOUS LEUKEMIA</u> DUE TO (c) <u>5 MONTHS</u>					INTERVAL BETWEEN ONSET AND DEATH <u>5 MONTHS</u>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>APRIL 9, 1967</u> to <u>APRIL 9, 1967</u> , that (I) (we) last saw the deceased alive on <u>APRIL 9, 1967</u> , and that death occurred at <u>6:30 PM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>Norman K. Bohrer</u> M.D.					22b. DATE SIGNED <u>April 9, 1967</u>				
22c. PHYSICIAN'S NAME (Type) <u>Norman K Bohrer</u>					22d. ADDRESS <u>3231 SUPERIOR LANE BOWIE, MD.</u>				
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>					23b. DATE THEREOF <u>April 13, 1967</u>				
23c. NAME OF CEMETERY OR CREMATORY <u>Ft Lincoln Cemetery</u>					23d. LOCATION (City, town or county) (State) <u>Colmar Manor Pro Geo Md.</u>				
24. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>					25a. REC'D BY REGISTRAR <u>APR 12 1967</u>				
ADDRESS <u>Hyattsville, Md.</u>					25b. REGISTRAR'S SIGNATURE <u>J Charles George</u>				

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05708

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05708

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS 3922 Suitland Road	
3. NAME OF DECEASED (Type or print) First Middle Last Glenn Isadore Rothenberg		4. DATE OF DEATH Month Day Year 4 5 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 16 April 1945
9. AGE (In years lost birthday) yrs 21		10. UNDER YEAR Days Hours Min 4 5 19 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SAILOR		10b. KIND OF BUSINESS OR INDUSTRY U.S. NAVY	
11. BIRTHPLACE (State or foreign country) Ogden, UTAH		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME LICNEL ROTHENBERG		14. MOTHER'S M A DEN NAME Stella ROMERO	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes ACTIVE Duty		16. SOCIAL SECURITY NO 520-44-7973	
17. INFORMANT Sheila H. ROTHENBERG		Address 3922 Suitland Rd, Suitland, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Traumatic rupture of aorta and right atrium DUE TO And laceration of right lung (b) From trauma auto accident DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Driver of car which ran off road and hit cement pillar.	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 2:10am 4-5- 19 67		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work of work Suitland Rd, 2000 ft. west of Arnold Rd.	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Prince George Co., Md.		20f. City or town or low (County) (State) Suitland Rd, 2000 ft. west of Arnold Rd.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED 4-6-67		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street city town or county)			
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF APRIL 7, 1967	23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL	23d. LOCATION (City or Town) (County) (State) Ft. Meyer Va
24. FUNERAL DIRECTOR W.W. Chambers	25a. REC'D BY REGISTRAR APR 10 1967	25b. REGISTRAR'S SIGNATURE Michaela Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

05709

CERTIFICATE OF DEATH

05713

1 PLACE OF DEATH a. COUNTY PRINCE GEORGE'S MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
ANDREWS AIR FORCE BASE DOA				HILLCREST HGTS			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
USAF HOSPITAL ANDREWS				2304 DAWSON ST.			
3 NAME OF DECEASED (Type or print) JOSEPH MILTON STONGE				4 DATE OF DEATH APRIL 4 19 67			
5 SEX MALE		6. COLOR OR RACE CAU		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8 DATE OF BIRTH 7 APRIL 1913	
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 AGE (In years last birthday) 53		10 IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12 CIT ZEN OF WHAT COUNTRY?	
RETIRED NAVAL OFFICER US NAVY				MERIDEN, CONN		USA	
13. FATHER'S NAME JOSEPH E. ST ONGE				14. MOTHER'S MAIDEN NAME SARAH JANE WALSH			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT Address			
YES 1931-1961				MRS MARY E. STONGE SAME AS # 2			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aneurysm inferior mesenteric artery with rupture and hemorrhage. 45-58 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH hours	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (A) (this hospital) attended the deceased from 7 MARCH, 1967, to 4 APRIL, 1967, that (4) (we) last saw the deceased alive on 29 MARCH 1967, and that death occurred at 820P M, from causes on and on the date stated above.							
22a. SIGNATURE <i>Arthur A. Altman</i> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22b. DATE SIGNED 5 APRIL 1967			
22c. PHYSICIAN'S NAME (Type) ARTHUR A. ALTMAN, MAJ, USAF, MC				22d. ADDRESS USAF HOSPITAL ANDREWS, ANDREWS AFB, WASH, D.C. 20341			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or town) (County) (State)	
Burial		Apr. 7-1967		Arlington Nat'l.		Arlington, Virginia	
24. FUNERAL DIRECTOR <i>St. Johns Bros</i> ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
St. Johns Bros. 1661-Good Hope Rd SE Wash DC				APR 7 1967		<i>Charles Judge</i>	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05710

05709

1 PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) b. STATE CONNECTICUT c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GROTON MUNFORD COVE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AF BASE		c. LENGTH OF STAY IN lb 7 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF HOSPITAL ANDREWS		d. STREET ADDRESS 5 NEPTUNE DRIVE	
3 NAME OF DECEASED (Type or print) ALICE MESSER SAMPSON		4 DATE OF DEATH APRIL 11 19 67	
5 SEX FEMALE	6 COLOR OR RACE CAU	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 30 MAR 04
9 AGE (In years lost birthday) 63 yrs		10 IF UNDER 1 YEAR Months Days Hours Min	
10a. USJAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY NA	
11 BIRTHPLACE (County & State, or foreign country) CONCORD, MASS.		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME ADELBERT MESSER		14. MOTHER'S MAIDEN NAME CLARA CHAPLAIN	
15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO NA		16. SOCIAL SECURITY NO. 045-38-4688	
17. INFORMANT HUSBAND		Address SAME AS #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory & Cardiovascular failure</u> DUE TO (b) <u>Septic Shock</u> DUE TO (c) <u>Congestive Heart Failure</u>			INTERVAL BETWEEN ONSET AND DEATH 4 days 11 months
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Anemia, Chronic Renal Disease, Diabetes Mellitus</u>			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21 I certify that (I) (this hospital) attended the deceased from <u>4 April</u> , 19 <u>67</u> , to <u>11 April</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>11 April</u> , 19 <u>67</u> , and that death occurred at <u>12:20 PM</u> , from causes and on the date stated above			
22a. SIGNATURE <u>John Bristow MD</u>		22b. DATE SIGNED 11 April 67	
22c. PHYSICIAN'S NAME (Type) JOHN W. BRISTOW, CAPT USAF MC		22d. ADDRESS USAF Hospital Andrews Andrews AFB Wash DC 20331	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 4/13/67	23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL	23d. LOCATION (City or Town) (County) (State) ARLINGTON, VIRGINIA
24 FUNERAL DIRECTOR ROBERT E. WILHELM FUNERAL HOME 4308 SUTLAND ROAD, SUTLAND, MARYLAND		25a. RECEIVED BY REGISTRAR APR 17 1967 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05715

CERTIFICATE OF DEATH

05714

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Adelphi</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>New Jersey</u> b. COUNTY <u>Essex</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Maplewood</u>	
c. LENGTH OF STAY IN b. <u>3-26-67</u> <u>4-17-67</u>		d. STREET ADDRESS <u>70 Essex Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Paint Branch Nursing Home</u>		4. DATE OF DEATH Month <u>4</u> Day <u>17</u> Year <u>1967</u>	
3. NAME OF DECEASED (Type or print) <u>Clarence D. Scrom</u>		5. SEX <u>M.</u> 6. COLOR OR RACE <u>W.</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>1-27-1895</u>		9. AGE (In years last birthday) <u>72</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Truck Engineer</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>New York</u>		12. CIT. ZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Clarence Scrom</u>		14. MOTHER'S MAIDEN NAME <u>Addie Sawyer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>W.W.I.</u>		16. SOCIAL SECURITY NO. <u>145-03-3561</u>	
17. INFORMANT <u>Earle B. Scrom</u> Address <u>11451 Cherry Hill</u>		18. <u>M. Wallace Son</u> <u>Beltsville, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u> DUE TO (b) <u>Compulsive heart failure</u> DUE TO (c) <u>Myocardial infarction</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 mm.</u> <u>5 yrs.</u> <u>2 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Hemiplegia from previous C.V.A.</u>		19. WAS A JUPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (b) (this hospital) attended the deceased from <u>3-29</u> , 19 <u>67</u> , to <u>4-17</u> , 19 <u>67</u> , that (we) last saw the deceased alive on <u>4-12</u> , 19 <u>67</u> , and that death occurred at <u>11:51 AM</u> from causes and on the date stated above.			
22a. SIGNATURE <u>R.D. Banes M.D.</u>		22b. DATE SIGNED <u>4-17-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>R.D. Banes M.D.</u>		22d. ADDRESS <u>2513 Bulkington Rd. Adelphi, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-19-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Fair View Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Amsterdam, New York</u>	
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>APR 24 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05711

CERTIFICATE OF DEATH

05710

1 PLACE OF DEATH a COUNTY Prince Georges MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c LENGTH OF STAY IN TB 5 hours	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d STREET ADDRESS Box 297	
3 NAME OF DECEASED (Type or print) First Baby Middle Boy (A) Last Seal		4 DATE OF DEATH Month April Day 3 Year 1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH April 3, 1967
9 AGE (In years last birthday) yrs		10 UNDER 1 YEAR Months	11 UNDER 24 HRS Days
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (County & State, or foreign country) USA
13 FATHER'S NAME Larry Seal		14 MOTHER'S MAIDEN NAME Sandra Lee Shaw	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO. —	17 INFORMANT Larry Seal Address Same as 2
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Premature 776X DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (this hospital) attended the deceased from April 3, 1967 , to April 3, 1967 , that (I/we) last saw the deceased alive on April 3, 1967 , and that death occurred at 7:40 AM from causes and on the date stated above			
22a SIGNATURE Andrew G. Aronfy M.D.		22b DATE SIGNED April 4, 1967	
22c PHYSICIAN'S NAME (Type) Andrew G. Aronfy, M.D.		22d ADDRESS Prince Georges General Hospital	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 4-4-67	23c NAME OF CEMETERY OR CREMATORY Seals Farm	23d LOCATION (City or Town) (County) (State) Ethison, Mont. Md.
24 FUNERAL DIRECTOR Francis H. Barber		25a REC'D BY REGISTRAR APR 5 1967	
ADDRESS Laytonville, Md.		25b REGISTRAR'S SIGNATURE James J. [Signature]	

05712

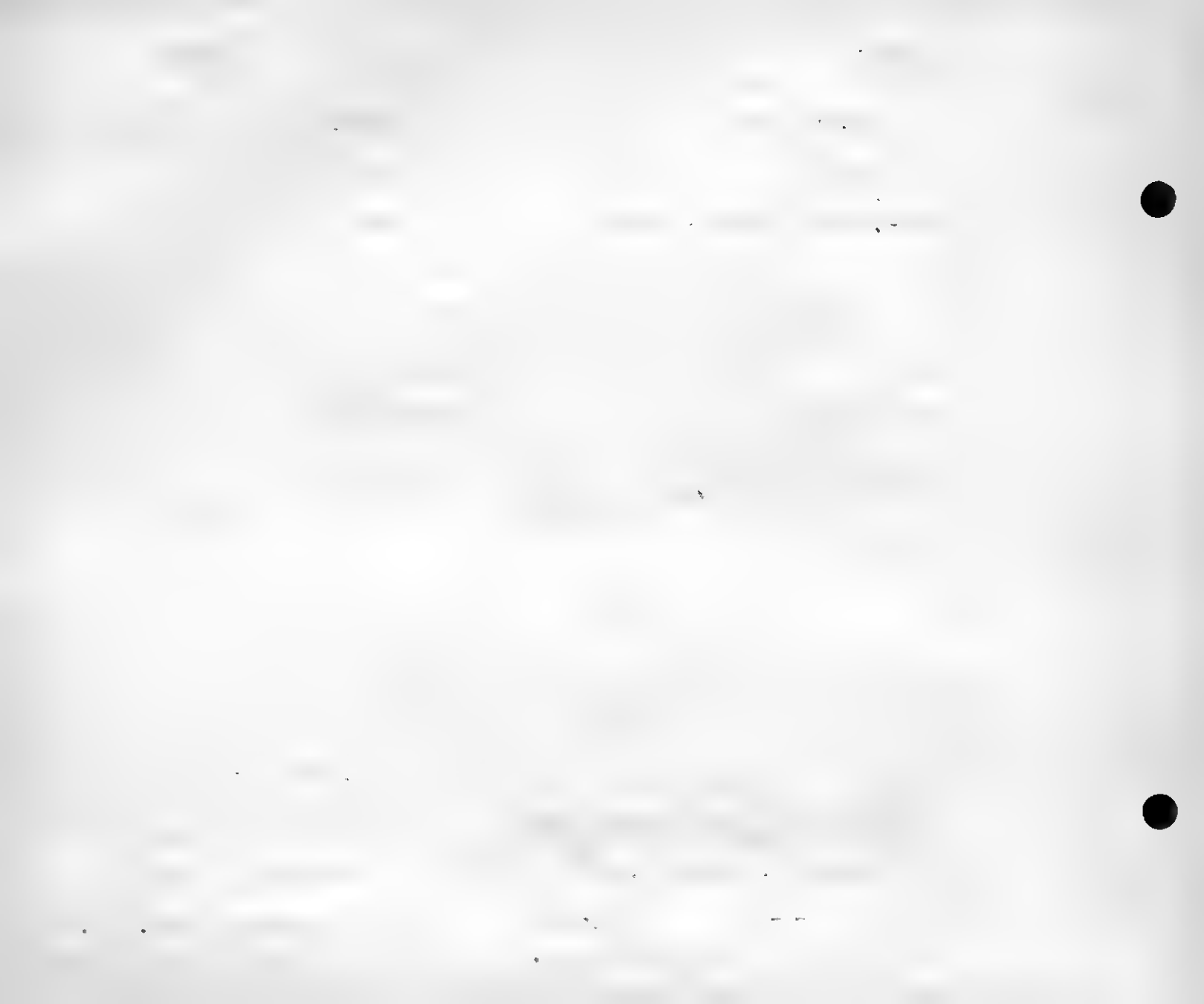
CERTIFICATE OF DEATH

05711

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 3 hrs	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jessup
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS Box 297	
3 NAME OF DECEASED (Type or print) First Baby Middle Boy (B) Last Seal		4. DATE OF DEATH Month 3 Day April Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3 April 1967
9. AGE (In years last birthday) yrs 3		10. UNDER 1 YEAR Months 3 Days 3 Hours 3 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Larry Seal		14. MOTHER'S MAIDEN NAME Sandra Lee Shaw	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO -	
17. INFORMANT Larry Seal		Address Same as 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Premature DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) 776X			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from April 3, 1967 , that (I) (we) last saw the deceased alive on April 3, 1967 , and that death occurred at 5:20 AM , from causes and on the date stated above.			
22a. SIGNATURE Andrew G. Aronfy M.D.		22b. DATE SIGNED 4/4/67	
22c. PHYSICIAN'S NAME (Type) Andrew G. Aronfy, M.D.		22d. ADDRESS Prince Georges General Hospital	
23a. BURIAL, CREMATION, or other disposition (Specify)	23b. DATE THEREOF 4-4-67	23c. NAME OF CEMETERY OR CREMATORY Seals Farm	23d. LOCATION (City or Town) (County) (State) Etchison Mont. Md.
24. FUNERAL DIRECTOR Francis H. Barber Laytonsville, Md.		25a. REC'D BY REGISTRAR APR 5 1967	25b. REGISTRAR'S SIGNATURE J. Charles Judge



FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05713

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05717

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN MD DOA	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		d. STREET ADDRESS 5913 Harrison Avenue	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MAUREEN Frances SHUMAKER Shoemaker Middle		4. DATE OF DEATH April 1 19 67 Month Day Year	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-29-46 9. AGE (in years last birthday) 20 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales		10b. KIND OF BUSINESS OR INDUSTRY TRAVEL CONSULTANTS, INC. WASHINGTON, D.C.	
11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME FRANCIS X. SHUMAKER		14. MOTHER'S MAIDEN NAME MARION RODDY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)		16. SOCIAL SECURITY NO NONE	
17. INFORMANT MRS. MARION SHUMAKER Address SAME AS #2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Laceration of brain			
8194 DUE TO (b) Trauma-Auto accident			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)			
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Driver of car involved in collision.	
20c. TIME OF INJURY Month, Day, Year 3:15AM 4-1-67 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rt. 495 east of Balto-Wash Pkwy. P.G. Md.		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Nature's causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe M.D.		22. DATE SIGNED 4-1-67	
EXAMINER'S NAME (Type) John Kehoe, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Charles Judge	
23a. BURIAL, CREMATION, RENAISSANCE BURIAL		23b. DATE THEREOF APRIL 4, 1967	
23c. NAME OF CEMETERY OR CREMATORY MT. OLIVET		23d. LOCATION (City or town) (County) (State) WASHINGTON, D.C.	
24. FUNERAL DIRECTOR W.W. CHAMBERS CO. RIVERDALE, MD		25a. REC'D BY REGISTRAR APR 4 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

CERTIFICATE OF DEATH

05714

05712

1 PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write Rural and give nearest town) Glenn Dale		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 10120 Dubarry Street		d. STREET ADDRESS 10004 Dubarry Street	
3. NAME OF DECEASED (Type or print) Frederick William Sinyard		4. DATE OF DEATH Month 4 Day 23 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 16, 1909
9. AGE (In years) 57		10. IF UNDER 1 YEAR Months 3 Days 16 Hours 16 Min 16	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baker		10b. KIND OF BUSINESS OR INDUSTRY Self Employed	
11. BIRTHPLACE (County & State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Sinyard		14. MOTHER'S MAIDEN NAME Margaret V. Fraley	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO 577 07 3017	
17. INFORMANT Catherine M. Sinyard Same as #2 (wife)		Address	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Coronary Artery occlusion with Infarction DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) 3 previous coronary attacks INTERVAL BETWEEN ONSET AND DEATH 3 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 3 previous coronary attacks			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not While of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb , 19 65 , to 4/23 , 19 67 , that (I) (we) last saw the deceased alive on 4/21 , 19 67 , and that death occurred at 4:30 P.M., from causes and on the date stated above.			
22a. SIGNATURE H. James Kurtz		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) H. James Kurtz		22d. ADDRESS KFD Glenn Dale Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/26/67	
23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d. LOCATION (City or Town) (County) (State) Colmar Manor, P.G. Md.	
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE APR 26 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

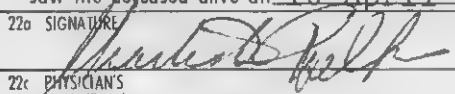

VR A15 (4)
20 M 1/66

05716

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05715

1 PLACE OF DEATH a. COUNTY PRINCE GEORGES b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE c. LENGTH OF STAY IN 1b 12 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF Hospital Andrews		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY DISTRICT OF COLUMBIA c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON d. STREET ADDRESS 1619 SUTERS LN N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) RUTH T SENTER		4. DATE OF DEATH Month APRIL Day 18 Year 19 67	
5 SEX FEMALE	6 COLOR OR RACE CAU	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 2-28-1916
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - -	9 AGE (In years last birthday) yrs 51
11 BIRTHPLACE (County & State, or foreign country) TENNESSEE		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME PHILLIP J. TINSLEY		14. MOTHER'S MAIDEN NAME SUSAN CUNYUS	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) - - -		16 SOCIAL SECURITY NO. - - -	
17. INFORMANT -LT.GEN'L. W.O. SENTER, SEE ITEM #9 Address			
18 CAUSE OF DEATH (Enter any one cause per line for (a) (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory Arrest DUE TO (b) Metastatic Carcinoma of Breast DUE TO (c) - - - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (it) (this hospital) attended the deceased from 6 April, 1967, to 18 April, 1967 , that (it) (we) last saw the deceased alive on 18 April 1967 , and that death occurred at 4:10 P.M. from causes and on the date stated above.			
22a SIGNATURE 		22b. DATE SIGNED 18 Apr 67	
22c PHYSICIAN'S NAME (Type) CHARLES D. PHELPS, CAPT USAF MC		22d. ADDRESS USAF Hospital Andrews Andrews AFB Wash DC 20331	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 4-21-1967	23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L. CEM.	23d. LOCATION (City or Town) (County) (State) ARLINGTON, VA.
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave. N.W. Wash. D.C.		25a REC'D BY REGISTRAR DATE APR 21 1967	
		25b. REGISTRAR'S SIGNATURE 	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

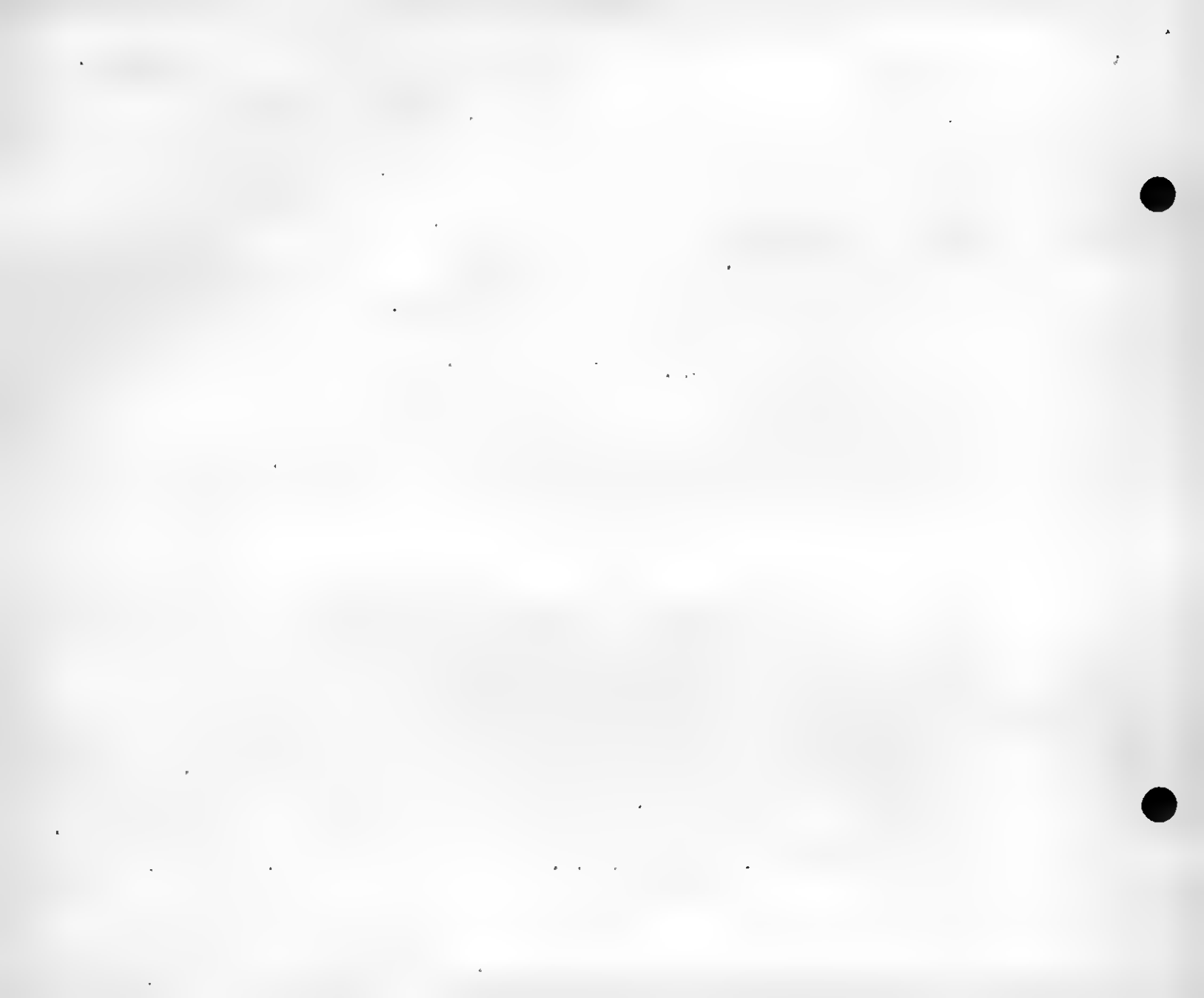
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CERTIFICATE OF DEATH

05717

05716

1. PLACE OF DEATH COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution on Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS 8-D Greenbelt, Md. 161 Hillside Road	
3. NAME OF DECEASED (Type or print) First Middle Last Shiren - Alvin		4. DATE OF DEATH Month Day Year April 12, 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/15/13
9. AGE (In years last birthday) 53 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ART DIRECTOR		10b. KIND OF BUSINESS OR INDUSTRY US. AIR FORCE	
11. BIRTHPLACE (County & State, or foreign country) BRONX, NEW YORK		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME LAZARUS SHIREN		14. MOTHER'S MAIDEN NAME SOPHIA ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 075-12-1999	
17. INFORMANT SCHWARTZ BROS. FOREST HILLS, LONG ISLAND		Address N.Y.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary embolism DUE TO (b) Myocardial infarction DUE TO (c) arterosclerosis heart Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 1-2 hours	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from Feb , 19 67 , to April 12, 1967 , that (I) (we) saw the deceased alive on April 12, 1967 , and that death occurred at 1:45 P.M. from causes and on the date stated above.			
22a. SIGNATURE William C. Weintraub, M.D.		22b. DATE SIGNED April 12, 1967	
22c. PHYSICIAN'S NAME (Type) William C. Weintraub, M.D.		22d. ADDRESS Professional Bldg. Greenbelt, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4/13/67	
23c. NAME OF CEMETERY OR CREMATORY MT. HEBRON		23d. LOCATION (City or Town) (County) (State) FLUSHING, NEW YORK	
24. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC., 6010 REIST., RD.		25a. REC'D BY REGISTRAR APR 14 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



05718

CERTIFICATE OF DEATH

05718

1 PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		MARYLAND c. LENGTH OF STAY IN lb 2 days		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D/C. Bradbury Height		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last John C Sims				4 DATE OF DEATH Month Day Year April 12 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5 April 1897		9. AGE (In years last birthday) 70 yrs	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Railroad Express		11. BIRTHPLACE (County & State, or foreign country) Alabama		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jeptha P. Sims				14. MOTHER'S MAIDEN NAME Janie Mc Colleston			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW 1		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Lela J. Sims (Wife) # 2.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY 171X Generalized Carcinomatosis IMMEDIATE CAUSE (a) DUE TO Carcinoma of prostate Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from Feb. 6, 1967 , to April 12, 1967 , that (I) (we) last saw the deceased alive on April 12, 1967 , and that death occurred at 4:40 PM , from causes and on the date stated above.							
22a. SIGNATURE Julius Kauffman M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4/13/67	
22c. PHYSICIAN'S NAME (Type) Julius Kauffman, M.D.				22d. ADDRESS 6501 Landover Rd. Cheverly, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 15-67		23c. NAME OF CEMETERY OR CREMATORY Oedar Hill Cemetery		23d. LOCATION (City or town) (County) (State) Suitland, Maryland	
24. FUNERAL DIRECTOR Simmons Bros.				ADDRESS 1661- Gd. Hope Rd. SE. Wash., DC		25a. REC'D BY REGISTRAR APR 14 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and a copy sent within 72 hours after death.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05719

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05719

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY, IN 1b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		e. STREET ADDRESS 4513 Rena Rd., Apt. 101	
3. NAME OF DECEASED (Type or print) Frances Gravely Slason		4. DATE OF DEATH Month 4 Day 20 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W. DOWED <input type="checkbox"/> D. VORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-23-1923
9. AGE (In years last birthday) 43 yrs		10. USUAL OCCUPATION (Give kind of work done during last 12 months, even if retired) Housewife	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Clay Webster Gravely		14. MOTHER'S MAIDEN NAME Mary Lou Harbin	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT Frank Kane Slason same as #2		Address	
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hepatic failure DUE TO Cirrhosis of the liver Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c)		INTERVAL BETWEEN ONSET AND DEATH days unknown	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspect on <input checked="" type="checkbox"/> , inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John Kenoe</i> EXAMINER'S NAME (Type) John Kenoe, M.D. Riverdale, Md.		22. DATE SIGNED 4-21-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 4/24/67	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or town) _____ (County) _____ (State) _____ Suitland, Md.	
24. FUNERAL DIRECTOR Wm. H. Hines Company 2901 14th St. N.W. Washington		25a. REC'D BY REGISTRAR Charles Judge	

APR 24 1967



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #7 File #G388 4/25/67 pc

05720

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05720

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE New York b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b DCA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Buffalo	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital			d. STREET ADDRESS 79 Nottingham Terrace		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Clayton M. Smith			4. DATE OF DEATH Month Day Year 4 17 19 67		
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10 Aug., 1884		9. AGE (In years, lost birthday) 82 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) New York	
13. FATHER'S NAME Anselm J. Smith			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO		17. INFORMANT Hospital Records Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure DUE TO (b) Arteriosclerotic heart disease DUE TO (c) Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last					INTERVAL BETWEEN ONSET AND DEATH Minutes over 3 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John Kehoe EXAMINER'S NAME (Type)		M.D. John Kehoe, M.D., Riverdale		22. DATE SIGNED 4-17-67	
23a. BURIAL, CREMATION, REMOVAL, BODY		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY	
Burial		4/21/67		Forest Lawn Com.	
24. FUNERAL DIRECTOR Home Inc.		ADDRESS Nalley's Funeral Maryland		25a. REC'D BY REGISTRAR APR 19 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (help please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05721

CERTIFICATE OF DEATH

05721

1 PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale c. LENGTH OF STAY IN 1b 3 days		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Leland Memorial Hospital		d. STREET ADDRESS 5902-31st Street	
3. NAME OF DECEASED (Type or print) First Middle Last Mary None Speropoulos		4. DATE OF DEATH Month 4 Day 22 Year 19 67	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-5-96
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Greece		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Kakavos		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Medical records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 170X Cerebral vascular accident DUE TO (b) Metastatic carcinoma DUE TO (c) Carcinoma right breast		INTERVAL BETWEEN ONSET AND DEATH 3 days 3 days 30 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 11/18, 1966, to 4/22, 1967, that (I) (we) last saw the deceased alive on 4/22, 1967, and that death occurred at 9 P.M. from causes and on the date stated above.			
22a. SIGNATURE Earl W. Graeffe		22b. DATE SIGNED 4/23/67.	
22c. PHYSICIAN'S NAME (Type) EARL W. GRAEFFE, M.D.		22d. ADDRESS 2416 Kinkwood Pl. W. Hyattsville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4/26/67	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d. LOCATION (City or Town) Suitland, Maryland (County) (State)
24. FUNERAL DIRECTOR Jas. T. Ryan, Inc.		25a. REG. BY REG. STRAR 25b. REG. STRAR'S SIGNATURE Charles Judge	

DATE APR 26 1967

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reattach carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05722

05722

1 PLACE OF DEATH a. COUNTY Prince Georges MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forestville		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forest Heights 16'	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Regent Nursing Home			d. STREET ADDRESS 310 Onondaga Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First Middle Last MAY B Stewart			4. DATE OF DEATH Month Day Year 4 20 19 67		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/1/1893		9. AGE (In years last birthday) 74 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (County & State, or foreign country) Ohio	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Frank Hausch		
14. MOTHER'S MAIDEN NAME Anna Mary Johnson			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		
16. SOCIAL SECURITY NO.			17. INFORMANT Mary Bell Shenherd Same as #2		
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Metastatic Carcinoma of Cervix DUE TO (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 1 yr
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 3-3, 1967, to 4-20, 1967, that (I) (we) last saw the deceased alive on 4-19, 1967, and that death occurred at 8:30 A.M. from causes on and on the date stated above.			
22a. SIGNATURE W.B. Sheer		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4-20-67	
22c. PHYSICIAN'S NAME (Type) WALTER B. SHEER		22d. ADDRESS 6400 MARLBORO PKE S.E. WASH. D.C. 20005			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/22/67		23c. NAME OF CEMETERY OR CREMATORY Boston Hgts. Cem.	
23d. LOCATION (City or Town) (County) (State) Summit County Ohio		24. FUNERAL DIRECTOR J. Wm. Lees Sons, Washington, D. C.			
25a. REC'D BY REGISTRAR DATE APR 21 1967		25b. REGISTRAR'S SIGNATURE M. L. L. L.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove, carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Prince Geo.						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville						c. LENGTH OF STAY IN 1b 7 mos. 18 days					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Carroll Manor Home for the Aged						e. STREET ADDRESS 5023 - Riverdale Road					
3. NAME OF DECEASED (Type or print) First Annie Middle K. Last Stickney						4. DATE OF DEATH Month April Day 2 Year 1967					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/15/1876		9. AGE (In years last birthday) 90		IF UNDER 1 YEAR Months 16 Days 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (County & State, or foreign country) Canada			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John Kenney						14. MOTHER'S MAIDEN NAME Elizabeth Smith					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 578-62-3516 J1		17. INFORMANT Mr. Geo. F. Stickney (above add- (Son))					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Toxic myocarditis & failure 442X DUE TO (b) Cardio-vascular renal degenerative Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from August, 1966 , to April 2, 1967 , that (I) (we) last saw the deceased alive on April 2, 1967 , and that death occurred at 11:45 A.M. from the causes and on the date stated above.											
22a. SIGNATURE Frank R. Shea						22b. DATE SIGNED 4/3/67					
22c. PHYSICIAN'S NAME (Type) FRANK R. SHEA						22d. ADDRESS 4100 - 22nd St NE Wash DC 20015					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/8/1967		23c. NAME OF CEMETERY OR CREMATORY St. Rose of Lima Com.				23d. LOCATION (City, town or county) (State) Littletown, N.H.			
24. FUNERAL DIRECTOR Home Inc. Nalley's Funeral Home						25a. REC'D BY REGISTRAR APR 7 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05724

05724

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN lb 8 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seat Pleasant d. STREET ADDRESS 6909 Adel St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Gladys B. Taylor		4. DATE OF DEATH Month Day Year April 5, 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/11/01
9. AGE (In years last birthday) 65 yrs		10. F UNDER 1 YEAR Months Days 6 5	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Govt P.O.	
11. BIRTHPLACE (County & State, or foreign country) Austin, Texas		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Bonte		14. MOTHER'S MAIDEN NAME Tutt	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 449-01-6257	
17. INFORMANT Bradford L. Taylor		Address Same as # 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Adenocarcinoma of the in testines 1539 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Metastases, widespread in abdomen DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the deceased) attended the deceased from March 27, 19 67 , to April 5, 19 67 , that (I) (we) last saw the deceased alive on April 5, 19 67 , and that death occurred at 8:55 AM from causes and on the date stated above.			
22a. SIGNATURE Peter Duus		22b. DATE SIGNED April 5, 1967	
22c. PHYSICIAN'S NAME (Type) Peter Duus, M.D.		22d. ADDRESS 6124 Central Ave. Capitol Hghts. Md.	
23a. BURIAL CREMATION Burial	23b. DATE THEREOF 4-8-1967	23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln	23d. LOCATION (City or Town) (County) (State) Prince George Co Maryland
24. FUNERAL DIRECTOR Metzgerly 131-11th St. S.E. D.C.		25a. REC'D BY REGISTRAR DATE APR 7 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

CERTIFICATE OF DEATH

05725

05725

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Magnolia Gardens Nursing Home		e. STREET ADDRESS RFD Box 4010	
3. NAME OF DECEASED (Type or print) Arthur Raleigh Tayman		4. DATE OF DEATH Month April Day 18 , Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 2, 1887
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months 7 Days 18 IF UNDER 24 HRS Hours 18 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tobacco Farming		10b. KIND OF BUSINESS OR INDUSTRY Tenant	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13. FATHER'S NAME Richard Henry Tayman		14. MOTHER'S MAIDEN NAME Eleanor-----	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-42-6805	
17. INFORMANT Mrs. Virginia K. Phillips		Address RR Box 4799 Upper Marlboro, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Renal failure Conditions, if any, which gave rise to immediate cause (b) Arteriosclerotic cardiovascular disease (c) steering the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) Interval between onset and death			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from August 18, 1967 to April 18, 1967 , that (I) (we) last saw the deceased alive on April 18, 1967 , and that death occurred at 4:15 P.M. from the causes and on the date stated above.			
22a. SIGNATURE A. Clark Holmes, M.D.		22b. DATE SIGNED 4/18/67	
22c. PHYSICIAN'S NAME (Type) A. Clark Holmes, M.D.		22d. ADDRESS Upper Marlboro, Maryland 20870	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4/22/67	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	23d. LOCATION (City, town or county) (State) Suitland Maryland
24. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Upper Marlboro, Md.		25. REC'D BY REGISTRAR MAY 4 1967 25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

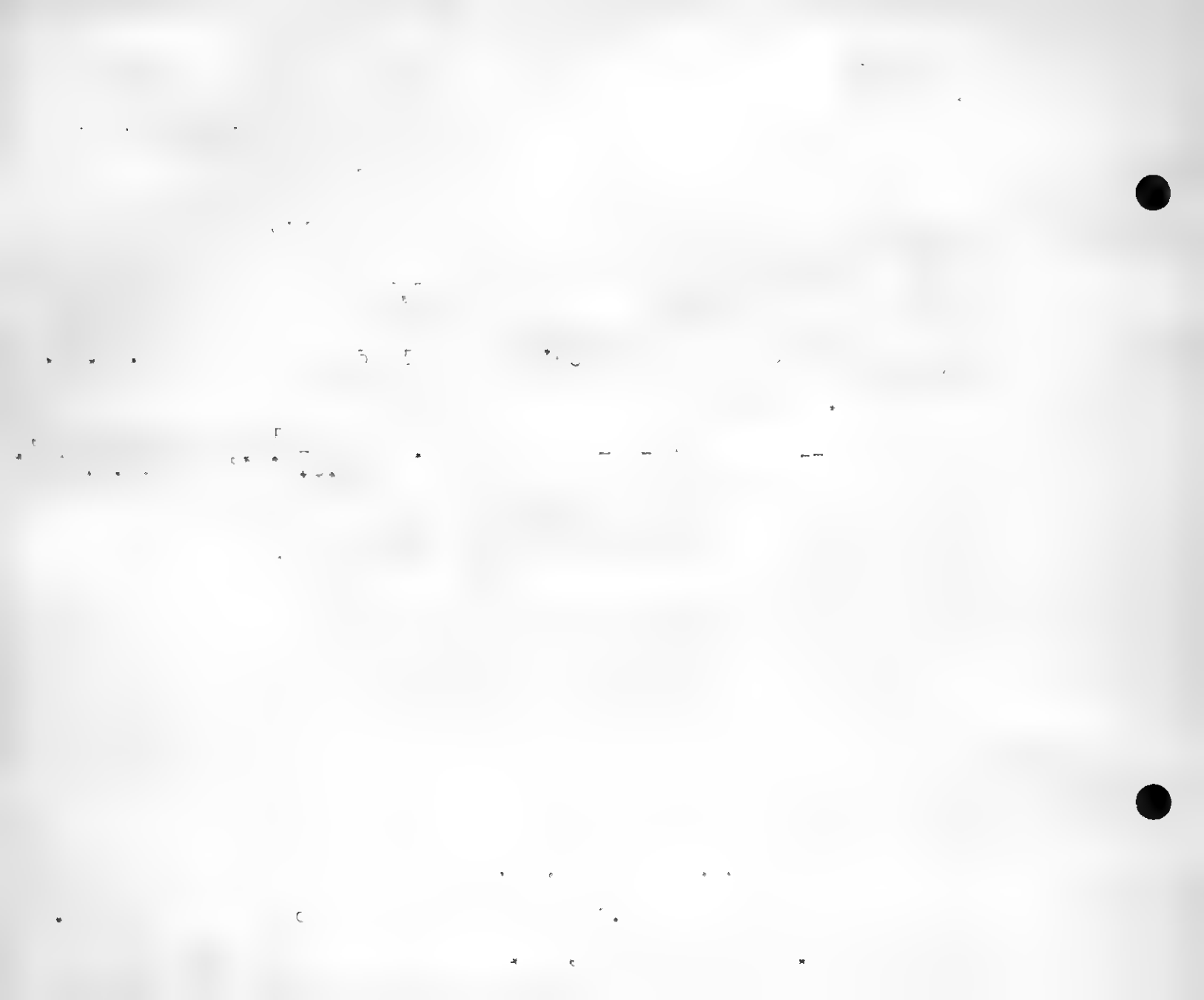
FOR STATE HEALTH DEPT.

05726

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05726

1 PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN b DOA d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		2 USUAL RESIDENCE (Where deceased lived, if institution residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Forestville d. STREET ADDRESS 8114 Redwood Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Claude Zaddock Tayman 5 SEX Male 6 COLOR OR RACE White 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Employed District Foreman 10b. KIND OF BUSINESS OR INDUSTRY Public Works		4 DATE OF DEATH March 1, 1967 9 AGE (in years last birthday) 61 11 BIRTHPLACE (State or foreign country) Maryland 12 CITIZEN OF WHAT COUNTRY U. S. A.	
8 FATHER'S NAME Claude W. Tayman		14 MOTHER'S MAIDEN NAME May Smith	
13 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO. 214-28-7634	
17 INFORMANT Ruth A. Tayman		18 ADDRESS 8114 Redwood Drive, Forestville, Md. (P.O. Washington, D.C. 20028)	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute pulmonary edema DUE TO (b) Occlusion of anterior descending artery by thrombus and hemorrhage into plaque. DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 18) 	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) (County) (State) 	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe M.D. EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		22. DATE SIGNED 4-7-67	
23a. BURIAL CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 4/9/67	
23c. NAME OF CEMETERY OR CREMATORY St. Thomas Cemetery		23d. LOCATION (City or town) (County) (State) Croom Md.	
24. FUNERAL DIRECTOR Ritchie Bros. Upper Marlboro, Md.		25a. REC'D BY REGISTRAR APR 12 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. If an please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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99

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
05727				CERTIFICATE OF DEATH				05727			
1 PLACE OF DEATH a. COUNTY <i>Prince Georges County</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Riverdale</i> c. LENGTH OF STAY IN 1b <i>D. O. A.</i> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Leland Memorial Hospital</i>						2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i> d. STREET ADDRESS <i>11610 Gail Place</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3 NAME OF DECEASED (Type or print) <i>Silverstein</i>						4. DATE OF DEATH Month <i>April</i> Day <i>22</i> Year <i>1967</i>					
5. SEX <i>male</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Oct 2, 1887</i>		9. AGE (In years last birthday) <i>79</i> yrs		10. UNDER 1 YEAR Months <i>1</i> Days <i>1</i> Hours <i>1</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Auto Painter Ret.</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Automotive</i>		11. BIRTHPLACE (County & State or foreign country) <i>North Carolina</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Hinton Jew</i>						14. MOTHER'S MAIDEN NAME <i>Unknown</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO <i>None</i>		17. INFORMANT <i>Clarence Jew</i>		Address <i>4508 Landgreen Street Rockville, Maryland</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute myocardial infarction</i> DUE TO (b) <i>arteriosclerotic heart disease</i> DUE TO (c) <i>1 year</i>										INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>10/31</i> , 19 <i>66</i> , to <i>4/22</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>4/20</i> , 19 <i>67</i> , and that death occurred at <i>11:40 PM</i> , from causes and on the date stated above.											
22a. SIGNATURE <i>S. B. Washington</i>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>4/24/67</i>			
22c. PHYSICIAN'S NAME (Type) <i>D. P. Washington M.D.</i>						22d. ADDRESS <i>5702 Ridgefield Rd. Bethesda Md</i>					
23a. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Apr 25, 1967</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Parklawn Cemetery</i>			23d. LOCATION (City or Town) (County) (State) <i>Rockville, Maryland</i>				
24. FUNERAL DIRECTOR <i>John B. Thomas Warner E. Humphrey, Inc.</i>						ADDRESS <i>8434 Georgia Avenue Silver Spring, Md.</i>		25a. REC'D BY REG-STRAR DATE <i>APR 27 1967</i>		25b. REGISTRAR'S SIGNATURE <i>R. Charles Jones</i>	

VR A15 (4)
20 M 1/66

FOR STATE
HEALTH DEPT

05729

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05729

1 PLACE OF DEATH a COUNTY Prince George's b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forestville c LENGTH OF STAY IN 1b DOA				2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Washington D.C.			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Andrew's Air Force Base Hospital				d STREET ADDRESS 1442 E Street, S.E.			
3 NAME OF DECEASED (Type or print) Ernest				4 DATE OF DEATH Month Day Year 4-7-67			
5 SEX male	6 COLOR OR RACE Negro	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 5-12-14	9 AGE (In years last birthday) yrs 52	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min.
10a SOCIAL OCCUPATION (Give kind of work done during most of work and 16, even if retired) Retired				10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) Leesville, Va.	
13. FATHER'S NAME C. P. Sullivan				14. MOTHER'S M A D E N NAME Hattie Toller			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16 SOCIAL SECURITY NO		17 INFORMANT James Redd Address 5101 Fitch St SE Wash DC	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Arteriosclerotic Heart Disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH over 1 yr.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 8)			
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe M.D. EXAMINER'S NAME (Type) John Kehoe M.D., Riverdale, Maryland				22. DATE SIGNED 4-8-67			
23a BURNING, REMOVAL, REMOVAL (Specify)		23b DATE HEREOF 4-12-67		23c NAME OF CEMETERY OR CREMATOR Family Plot		23d LOCATION (City or Town) (County) (State) Leesville, Va.	
24. FUNERAL DIRECTOR Batney Funeral Home, Wash, DC				APR 11 1967 DATE			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05730

05730

1 PLACE OF DEATH a. COUNTY <u>Prince Georges</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>		2 USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
c. LENGTH OF STAY IN 1b <u>10-1</u>		d. STREET ADDRESS <u>201 Hamilton Street</u>	
3 NAME OF DECEASED (Type or print) <u>Pearl M. Tonis</u>		4 DATE OF DEATH Month <u>4</u> Day <u>15</u> Year <u>1967</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 AGE (In years last birthday) <u>78</u> yrs
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>	11 BIRTHPLACE (County & State, or foreign country) <u>Hyattsville</u>
13 FATHER'S NAME <u>Samuel J. Calahan</u>		14 MOTHER'S MAIDEN NAME <u>Emma V. Long</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16 SOCIAL SECURITY NO <u>NONE</u>	
17 INFORMANT <u>hospital admission record</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>GEN. ARTERIOSCLEROSIS</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>12 DAYS</u> <u>UNKNOWN</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
20c TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <u>3-29</u> , 19 <u>67</u> , to <u>4-15</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4-14</u> , 19 <u>67</u> , and that death occurred at <u>5 AM</u> , from causes and on the date stated above.			
22a SIGNATURE <u>C. J. Houmann</u>		22b. DATE SIGNED <u>4-15-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>C. J. HOUMANN</u>		22d ADDRESS <u>RIVERDALE MD</u>	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
<u>Burial</u>	<u>APRIL 18, 1967</u>	<u>FT. LINCOLN CEM.</u>	<u>BLADENSBURG MD.</u>
24 FUNERAL DIRECTOR <u>W. W. Chambers & Sons, Inc.</u>		25a REC'D BY REGISTRAR DATE <u>APR 20 1967</u>	25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if only day is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05731

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05731

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b D. O. A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Leland Memorial Hospital		d. STREET ADDRESS 5118 Kenilworth Avenue	
3. NAME OF DECEASED (Type or print) DENNIS EVERETT TREVETT		4. DATE OF DEATH Month April Day 24 Year 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 20, 1959
9. AGE (in years last birthday) yrs 8		10. F UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY School	
11. BIRTHPLACE (State or foreign country) South Dakota		12. CITIZEN OF WHAT COUNTRY? U.S. A.	
13. FATHER'S NAME Donald E. Trevett		14. MOTHER'S MAIDEN NAME Cynthia E. Groff	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO none	
17. INFORMANT Donald E. Trevett Same as #2 (father)		Address	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO Congenital heart disease (b) (tetralogy of fallot) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		INTERVAL BETWEEN ONSET AND DEATH minutes	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe EXAMINER'S NAME (Type) John Kehoe, M. D. Riverdale, Md.		22. DATE SIGNED 4-24-67	
23a. BURIAL, CREMATION, REQUIEM (Specify) Burial		23b. DATE THEREOF 4/28/67	
23c. NAME OF CEMETERY OR CREMATORY Elmwood		23d. LOCATION (City or Town) (County) (State) Adams N. Y.	
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE APR 26 1967	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05732

05732

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) b. STATE Maryland c. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 31 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berwyn Heights	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				d. STREET ADDRESS 5312 Pontiac Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last Sophie Katherine Triesler				4 DATE OF DEATH Month Day Year 4 29 1967			
5 SEX female		6 COLOR OR RACE white		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH 3-28-1872	
9 AGE (In years last birthday) 95 yrs		10 FINDER 1 YEAR Months Days		11 FINDER 24 HRS Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11 BIRTHPLACE (State or foreign country) Stuttgart Germany	
12 CITIZEN OF WHAT COUNTRY? USA							
13 FATHER'S NAME (unknown) Wager				14 MOTHER'S MAIDEN NAME No Record			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOC. SEC. NO. None		17 INFORMANT Address Adolph W. Triesler 5912 Pontiac St			
18 CAUSE OF DEATH (Enter on any cause per line for (a), (b), and (c)) PART I. DEATH CAUSED BY IMMEDIATE CAUSE (a) 4200 Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 1 week years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Intertrochanteric fracture of right hip							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) fell at nursing home (Magnolia Gardens)			
20c. TIME OF INJURY Month, Day Year Hour am pm 6:00pm 3-29 1967		20e. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, off highway, etc.) nursing home		20f. (City or town) (County) (State) Lanham P.G. Md.	
21 I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Indetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe M.D.				22. DATE SIGNED XXXX 4-30-67			
EXAMINER'S NAME (Type) John Kehoe M.D., Riverdale, Md.				Address (Street, city, town, or county) Hagerstown Md.			
23a. PLACE OF CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/2/67		23c. NAME OF CEMETERY OR CREMATORY Hausoleum Rose Hill Cem Hagerstown Wash Co Md		23d. LOCATION (City or town) (County) (State) Hagerstown Md.	
24. FUNERAL DIRECTOR Andrew K. Coffman Funeral Home Inc.				25. REC'D BY REG. STRAR MAY 3 1967		25b. REG. STRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05733		05733	
1. PLACE OF DEATH a. COUNTY PRINCE GEORGE b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HYAHSVILLE c. LENGTH OF STAY IN 1b 2 YRS. 8 days. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) CARROLL MANOR.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON D.C. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON D.C. d. STREET ADDRESS 1942 400 PLACE S.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ARTHUR DOMINIC UNDERWOOD 1. SEX MALE 2. COLOR OR RACE white 3. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 4. DATE OF BIRTH JUNE 30, 1893 5. AGE (In years last birthday) 73 yrs. 6. IF UNDER 1 YEAR Months Days 7. IF UNDER 24 HRS. Hours Min.		4. DATE OF DEATH APRIL 3 1967 Month Day Year	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CREDIT DEPT. 10b. KIND OF BUSINESS OR INDUSTRY WASH. GAS. LIGHT. 11. BIRTHPLACE (County & State, or foreign country) WASHINGTON D.C. 12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME BENJAMIN Underwood 14. MOTHER'S MAIDEN NAME MARY Foley			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO 16. SOCIAL SECURITY NO. 579-03-2005 17. INFORMANT Helen Underwood Address Wash. D.C. 1942 400 PLACE S.E.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST CEREBRAL VASCULAR INSUFF GENERALIZED ATHEROSCLEROSIS CONDITIONS, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (b) CERE DUE TO (c) CERE PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDIT. ON GIVEN IN PART I. (a) POST RESECTION CA OF TONSIL & MELANOMA 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH MINS 2 YRS. YRS.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from March 28, 1967, to April 3, 1967, that (I) (we) last saw the deceased alive on March 28, 1967, and that death occurred at 4:25 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Harold W. Draper M.D. 22c. PHYSICIAN'S NAME (Type or print) HAROLD W. DRAPER M.D. 22b. DATE SIGNED 4/3/67 22d. ADDRESS 911 SILVER SPRING AVE SPRING			
23a. BURIAL, CREMATION, REMOVAL, (Specify) Burial 23b. DATE THEREOF 4-7-1967 23c. NAME OF CEMETERY OR CREMATORY Oceday Hill 23d. LOCATION (City, town or county) (State) Southland, Md			
24. FUNERAL DIRECTOR'S SIGNATURE Matthew 131-11th St. S.E. D.C. 25a. REC'D BY REGISTRAR DA APR 5 1967 25b. REGISTRAR'S SIGNATURE J. Charles Judge			

05734

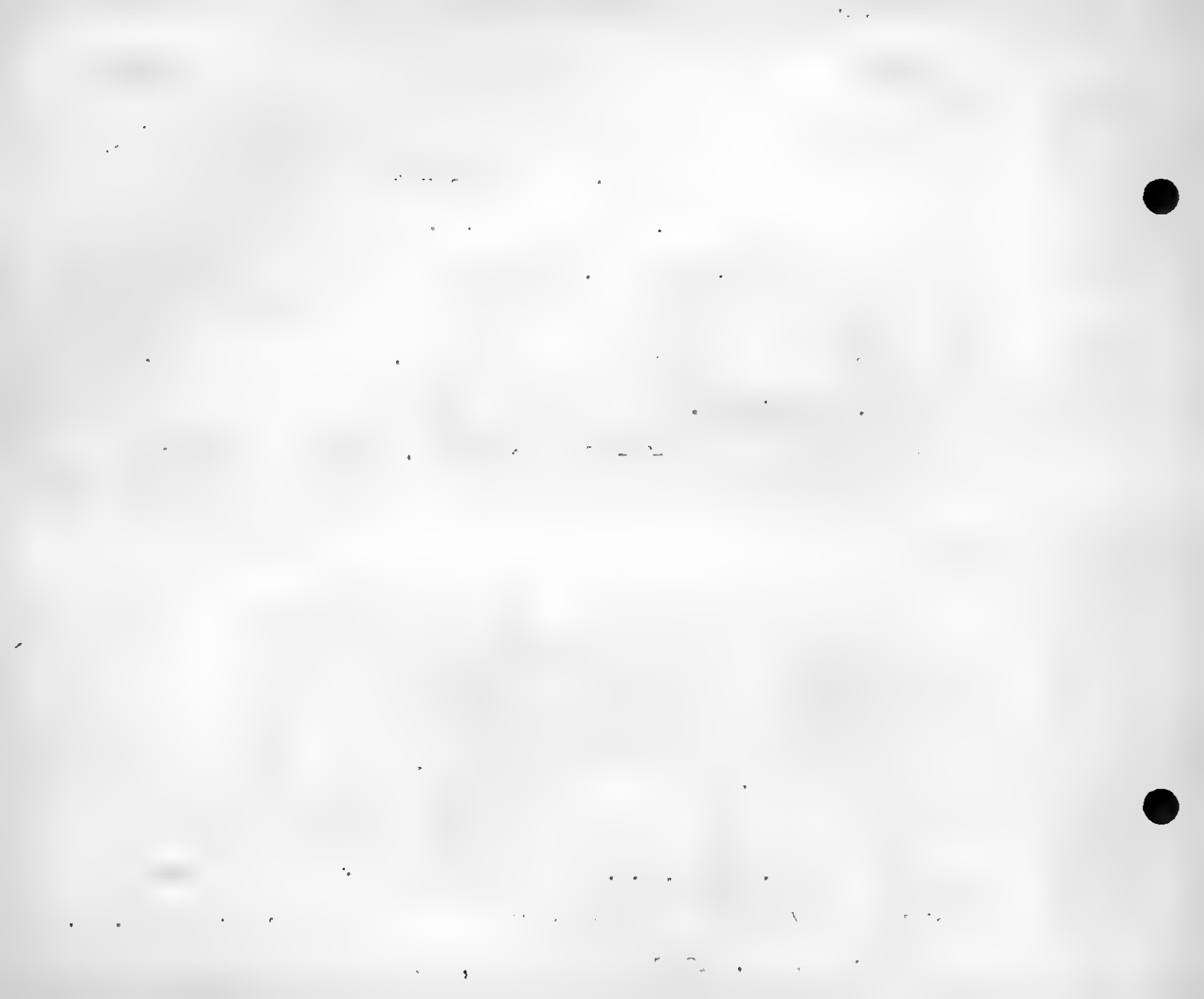
CERTIFICATE OF DEATH

05734

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 1 hr. 25 mins d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Accokeek d. STREET ADDRESS P. O. #64 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ellwood G. Valentine		4. DATE OF DEATH Month April Day 14 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/8/08
9. AGE (In years (last birthday) yrs.) 58		10. F UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cab Driver		10b. KIND OF BUSINESS OR INDUSTRY Yellow Cab	
11. BIRTHPLACE (County & State, or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Elwood G. Valentine Sr.		14. MOTHER'S MAIDEN NAME Cecelia	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 579-22-9515	
17. INFORMANT Gertrude A. Valentine		Address Same As # 2	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema & Cardiac Arrest DUE TO (b) Probably coronary artery disease DUE TO (c) stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS A TOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that XX (this hospital) attended the deceased from April 14, 1967 , to April 14, 1967 , that XX (we) last saw the deceased alive on April 14, 1967 , and that death occurred at 8:40 AM , from causes and on the date stated above.			
22a. SIGNATURE Edwin J. Jensen		22b. DATE SIGNED April 14, 1967	
22c. PHYSICIAN'S NAME (Type) Edwin J. Jensen, M.D.		22d. ADDRESS Prince Georges General Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/17/1967	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION (City or Town) (County) (State) Suitland Prince Geo. Md.	
24. FUNERAL DIRECTOR W.W. Chambers Co. Inc. 517 11th St S.E. Wash. D.C.		25a. REC'D BY REGISTRAR APR 18 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05735

05735

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN TB 18 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET 5019 Gerinomo Street	
3. NAME OF DECEASED (Type or print) Violet M. Vanagas		4. DATE OF DEATH Month April Day 29 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 17 Oct., 1907
9. AGE (In years last birthday) 59 yrs		10. IF UNDER 1 YEAR Months Days Hours Min. 16 hrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John William MacKenzie		14. MOTHER'S MAIDEN NAME Francis Elizabeth Stiger	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 067 16 1652	
17. INFORMANT George Vanagas Same as #2 Son		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) myocardial infarct DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) cardiac arrest DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 16 hrs	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1966 , 19 7/29 , 19 8/10 that (I) (we) last saw the deceased alive on 4/29/67 , 19 4/29 , and that death occurred at 5:10 PM from causes and on the date stated above.			
22a. SIGNATURE Leon Levitsky, M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Leon Levitsky, M.D.		22d. ADDRESS 3408 R. I. Ave. Mt. Rainier, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/2/67	23c. NAME OF CEMETERY OR CREMATORY Arlington National	23d. LOCATION (City or Town) (County) (State) Arlington Va.
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR MAY 5 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05736

05736

FOR STATE
HEALTH DEPT



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN It DOA		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hillside	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Prince George General Hospital		d. STREET ADDRESS 5264 Marlboro Pike	
3 NAME OF DECEASED (Type or print) First Middle Last Mark Anthony Vidotto		4 DATE OF DEATH Month Day Year 4 16 19 67	
5 SEX male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 13 Feb. 1962
9 AGE (In years lost birthday) 5 yrs		10 IF UNDER 1 YEAR Months Days Hours Min	
10a. US JAIL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) Washington, DC		12 CITIZEN OF WHAT COUNTRY?	
13 FATHER'S NAME Mario Vidotto		14 MOTHER'S MAIDEN NAME Alice V. Robertson	
15 WAS DECEASED EVER IN US ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO	
17 INFORMANT Mario Vidotto		Address Same as Item No. 2	
18 CAUSE OF DEATH (Enter on any cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hemo-peritoneum 8124 DUE TO Laceration of liver Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) From trauma - DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Pedestrian struck by truck.	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 2:00pm 4-16-1967		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 5200 Block Marlboro Pike, Prince Geo. Co. Md.	
21 I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspect an <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED 4-17-67	
ACTUAL SIGNATURE John Kehoe M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		Address (Street, city, town or county)	
23a. BURIAL CREMATION REMOVAL (Specify) Burial	23b. DATE THEREOF Apr. 20-1967	23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery	23d. LOCATION (City or Town) (County) (State) Washington, DC
24. FUNERAL DIRECTOR Williams Bros. Williams Bros. 1661-Good Hope Rd SE Wash DC		25a. REC'D BY REGISTRAR APR 19 1967 25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25A 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05737

CERTIFICATE OF DEATH

07172

1 PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Alexandria		c. LENGTH OF STAY IN 1b 25 min.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) United Memorial Hospital		d. STREET ADDRESS 315 Laurel Avenue	
3 NAME OF DECEASED (Type or print) William, Essie C. Vogts		4 DATE OF DEATH Month 4 Day 20 Year 1967	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-3-81
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	9. AGE (In years last birthday) 85 yrs.
11. BIRTHPLACE (County & State, or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME James Beall		14. MOTHER'S MAIDEN NAME Elizabeth B urdette	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT Admitting record		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4331 HEART FAILURE DUE TO (b) ATRIAL? TACHYCARDIA DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH ONE DAY ONE DAY
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 3-29, 1967, to 4-28, 1967, that (I) (we) lost saw the deceased alive on 4-28, 1967, and that death occurred at 10:45 PM, from causes and on the date stated above.			
22a. SIGNATURE C.J. Houmann		22b. DATE SIGNED 4-28 67	
22c. PHYSICIAN'S NAME (Type) C.J. HOUMANN		22d. ADDRESS RIVERDALE MD	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 5-1-67	23c. NAME OF CEMETERY OR CREMATORY Saint Paul	23d. LOCATION (City or town) (County) (State) Laurel PR Md
24. FUNERAL DIRECTOR [Signature]		25a. REC'D BY REGISTRAR MAY 9 1967	
ADDRESS [Signature]		25b. REGISTRAR'S SIGNATURE [Signature]	

20. 2. 1978

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05738

CERTIFICATE OF DEATH

05737

1 PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 15 hrs	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairmont Heights
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS 1010 59th Ave.	
3 NAME OF DECEASED (Type or print) First Dorothy Middle Wallace Last Wallace		4. DATE OF DEATH Month April Day 9 Year 19 67	
5 SEX Female	6 COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 13 May 1930
9 AGE (In years last birthday) yrs 36		10. IF UNDER 1 YEAR Months 9 Days 19 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Never Worked		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (County & State, or foreign country) Washington DC		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Mr Edward Harrison		14. MOTHER'S MAIDEN NAME Flora Telliver Same as 2D	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. —	
17. INFORMANT Rosie Butler		Address 5554 B St. S.E. DC	
18 CAUSE OF DEATH (Enter only one cause per line 18 (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Acute pulmonary edema, bilateral DUE TO 47X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pneumonia, bil. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from April 8, 1967 , to April 9, 1967 , that (we) last saw the deceased alive on April 9, 1967 , and that death occurred 4:30 AM , from causes and on the date stated above.			
22a. SIGNATURE Edwin J. Jensen		22b. DATE SIGNED April 10, 1967	
22c. PHYSICIAN'S NAME (Type) Edwin J. Jensen, M.D.		22d. ADDRESS Prince Georges General Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) 4-13-67		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY Lincoln Cem.		23d. LOCATION (City or Town) (County) (State) Suitland Rd Md	
24. FUNERAL DIRECTOR H.S. Washington		25a. REC'D BY REGISTRAR APR 14 1967	
25b. REGISTRAR'S SIGNATURE J. H. Jones			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

71

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05733

CERTIFICATE OF DEATH

05738

1 PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 32 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		d. STREET ADDRESS 3400 Toledo Terr.	
3 NAME OF DECEASED (Type or print) Ozelle W. Waller		4 DATE OF DEATH Month Day Year April 2 19 67	
5 SEX Female	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 12 Nov., 1910
9 AGE (In years last birthday) 56 yrs.		10. IF UNDER 24 HRS. Months Days Hours Min.	
11 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inf. Spec.		12. CITIZEN OF WHAT COUNTRY U.S. A.	
13. FATHER'S NAME Robert W. Waller		14. MOTHER'S MAIDEN NAME Ada N. Johnson	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16 SOCIAL SECURITY NO. 457 74 2414	
17 INFORMANT Mrs. Gertie A. Alford		Address Ft. Worth, Texas	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) lung squamous cell ca of esophagus DUE TO (b) metastases to liver DUE TO (c) Recent partial esophagectomy, & gastrojejunostomy stating the underlying cause lost. preparation of gastro esophageal site - metastases			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 150X			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 3-3-67 , to 4-2-67 that (I) last saw the deceased alive on 4-1-67 , and that death occurred 12:30AM from causes and on the date stated above			
22a SIGNATURE A Deitz		22b DATE SIGNED 4/2/67	
22c. PHYSICIAN'S NAME (Type) Aaron Deitz, M. D.		22d. ADDRESS Prince George Plaza, Hyattsville, Md.	
23a BURIAL, CREMATION, or other disposition (Specify) BURIAL	23b DATE THEREOF 4/5/67	23c NAME OF CEMETERY OR CREMATORY Kappernal	23d LOCATION (City or Town) (County) (State) Keppernal Texas
24 FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.		25a REC'D BY REGISTRAR APR 5 1967	25b REGISTRAR'S SIGNATURE Charles Judge

05740

CERTIFICATE OF DEATH

05739

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN lb <u>8 hrs.17 min.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George's General Hospital</u>		d. STREET ADDRESS <u>4916 Deal Drive</u>	
3 NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Boy</u> Last <u>Wayman</u>		4. DATE OF DEATH Month <u>April</u> Day <u>6</u> Year <u>1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/6/67</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9 AGE (In years last birthday) yrs <u>0</u> Months <u>0</u> Days <u>0</u> Mins. <u>0</u>
11 BIRTHPLACE (County & State, or foreign country) <u>Prince George's, Maryland</u>		12 CIT ZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Hall Wayman</u>		14. MOTHER'S MAIDEN NAME <u>Carolyn Lillian Heiss</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17 INFORMANT <u>Mother</u>		Address <u>As above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ATELECTASIS, PUL, PULMONARY</u> DUE TO (b) <u>PREMATURITY (700 Grams)</u> DUE TO (c) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>—</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>April 6, 1967</u> , to <u>April 6, 1967</u> , that (I) (we) last saw the deceased alive on <u>April 6, 1967</u> , and that death occurred at <u>11 AM</u> , from causes and on the date stated above			
22a. SIGNATURE <u>Bernardo Alvarado, M.D.</u>		22b. DATE SIGNED <u>4/7/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Bernardo Alvarado, M.D.</u>		22d. ADDRESS <u>6211 Riverdale Rd., Riverdale, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE THEREOF <u>4/22/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Prince George's Gen. Hosp. Cheverly PG Maryland</u>	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR <u>Harry W. Penn, Jr., Admin., Cheverly, Md.</u>		25. REC'D BY REGISTRAR <u>APR 25 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1 '67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05741

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05740

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN TB DOA			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville				d. STREET ADDRESS 3617 65th. Avenue			
a. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George General Hospital				e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last Harold Leroy Weaver				4 DATE OF DEATH Month Day Year 4- 28 19 67			
5 SEX male	6 COLOR OR RACE white	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 12 Feb. 1914	9 AGE (in years last birthday) 53 yrs	10 UNDER 1 YEAR Months Days Hours Min		11 UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN			10b. KIND OF BUSINESS OR INDUSTRY TEL-ADDS		11 BIRTHPLACE (State or foreign country) WASH. D.C.		12 CITIZEN OF WHAT COUNTRY USA
13 FATHER'S NAME ERNEST J. WEAVER				14 MOTHER'S MAIDEN NAME MINNIE MORDORS			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES		16 SOCIAL SECURITY NO. 578-01-4929		17 INFORMANT Address MRS VIRGINIA C. WEAVER 1442 KENNEDY AVE ARLAND, VA			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c)							INTERVAL BETWEEN ONSET AND DEATH minutes over 14 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour am pm 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspect an <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Kehoe M.D.				22. DATE SIGNED 4-28-67			
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.				Address (Street city town or county)			
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5/1/67		23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN		23d. LOCATION (City or town) (County) (State) Prince Geo. Co. MD.	
24. FUNERAL DIRECTOR Wm. Chambers Co. St. Spencr				25a. REC'D BY REGISTRAR MAY 4 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

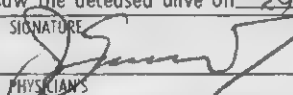
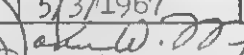

VR A15 (4)
20 M 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05742

CERTIFICATE OF DEATH

05741

1 PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AFB			c LENGTH OF STAY IN 1b 2 DAYS		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SEVERNA PARK		
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF HOSPITAL ANDREWS				d STREET ADDRESS 305 ST IVES ST		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last JAMES FRANKLIN WHISENAND				4 DATE OF DEATH Month Day Year APRIL 29 19 67			
5 SEX MALE		6 COLOR OR RACE CAU		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH February 9, 1911	
9 AGE (In years last birthday) 56 yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) USAF		10b KIND OF BUSINESS OR INDUSTRY USAF		11 BIRTHPLACE (County & State, or foreign country) BROWN CO. INDIANA	
12 CITIZEN OF WHAT COUNTRY? USA				13 FATHER'S NAME WALTER W WHISENAND			
14 MOTHER'S MAIDEN NAME MARY KATHERINE LIPPS				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES			
16. SOCIAL SECURITY NO. 557 05 1732		17. INFORMANT WIFE		Address SAME AS 2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROSIS, GENERALIZED DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 27 APRIL, 19 67 , to 29 APRIL, 19 67 , that (I) (we) last saw the deceased alive on 29 APRIL, 19 67 , and that death occurred at 3:30 PM , from causes on and on the date stated above.							
22a. SIGNATURE 				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 29 APRIL 67	
22c. PHYSICIAN'S NAME (Type) JOHN SIMONATIS, MAJ, USAF MC				22d. ADDRESS USAF HOSP ANDREWS AFB 20331			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/3/1967		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or Town) (County) (State) Fort Myer, Virginia	
24 FUNERAL DIRECTOR  The Demaine Funeral Homes, Inc., Alexandria, Va.				25a REC'D BY REGISTRAR MAY 2 1967		25b. REGISTRAR'S SIGNATURE 	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

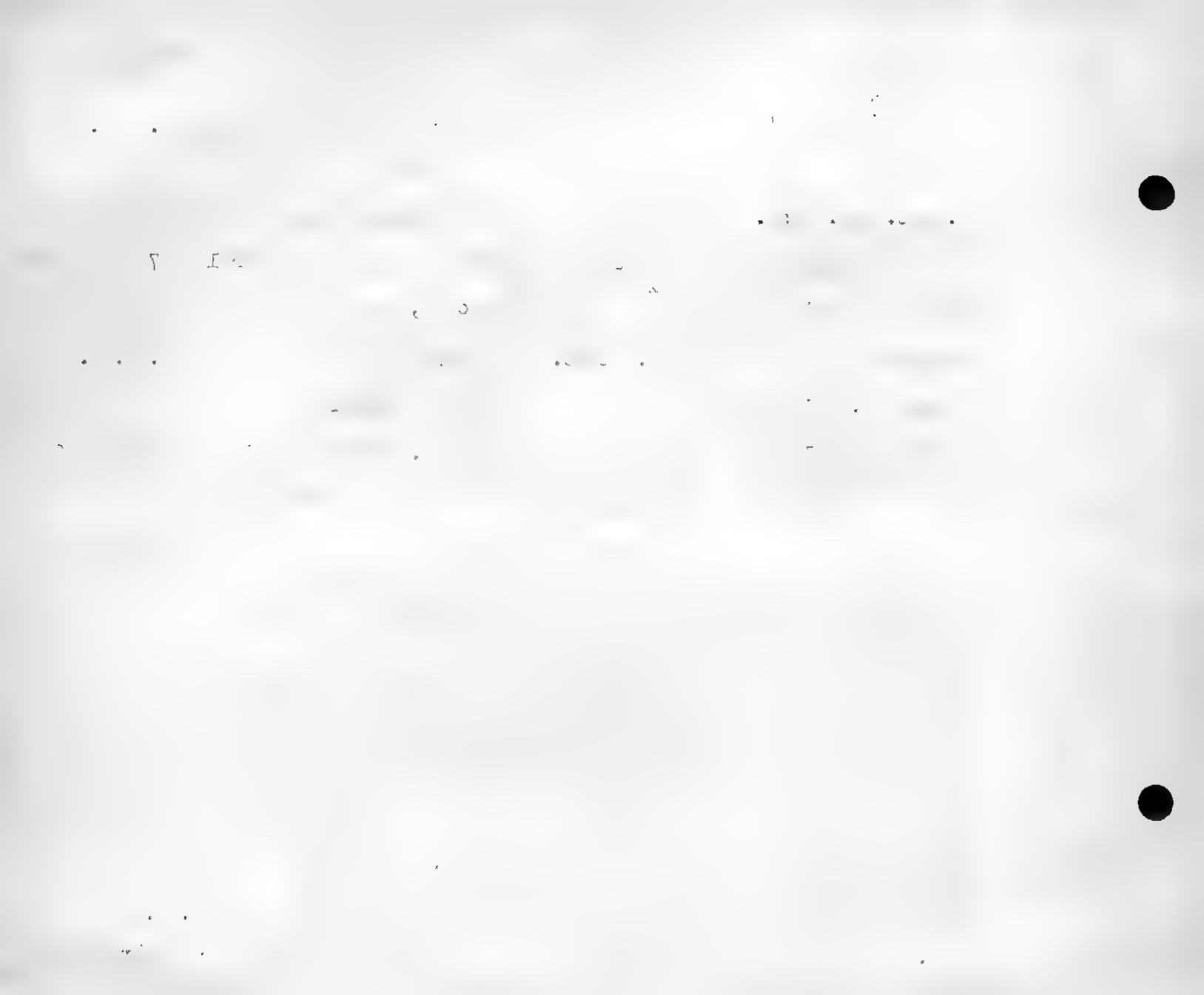
FOR STATE HEALTH DEPT.

05743

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05742

1 PLACE OF DEATH a COUNTY Prince George's MARYLAND				2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a STATE Maryland b COUNTY Pro. Geo.			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c LENGTH OF STAY IN b Oakland			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pr. Geo. Gen. Hosp.				d STREET ADDRESS 5505 Walker Mill Road			
e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3 NAME OF DECEASED (Type or print) SYDNEY MUDD WILDMAN				4 DATE OF DEATH Month April Day 7 Year 67			
5 SEX Male		6 COLOR OR RACE White		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH March 9, 1915	
9 AGE (in years birthday) yrs 52		F UNDER 1 YEAR Months Days Hours Min		I UNDER 24 HRS Months Days Hours Min			
10a LSAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter				10b KIND OF BUSINESS OR INDUSTRY Bldg. Const.		11. BIRTHPLACE (State or foreign country) Maryland	
12 CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Thomas H. Wildman				14. MOTHER'S MAIDEN NAME Lita Sheppard			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes, give year or dates of service) Yes WW II		16. SOCIAL SECURITY NO 579 10 4430		17. INFORMANT Dorothy G. Wildman		Address Wife Same as # 2	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Wildman Sub Sural DUE TO Hematoma (b) 2 days DUE TO Loceratin of Brain (c) 41				INTERVAL BETWEEN ONSET AND DEATH			
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Automobile accident fell from a car					
20c TIME OF INJURY Month Day, Year Hour pm 19 67		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office, etc.) Street		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Dayton Watkins		22. DATE SIGNED 4-7-67		22. DATE SIGNED			
EXAMINER'S NAME (Type) DAYTON O WATKINS		Address (Street, city, town, or county)					
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF April 10, 1967		23c NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery		23d LOCATION (City or Town) (County) (State) Washington D. C.	
24 FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.				25a REC'D BY REGISTRAR APR 10 1967		25b REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05744

Item #11 infor, taken from birth cert.

CERTIFICATE OF DEATH

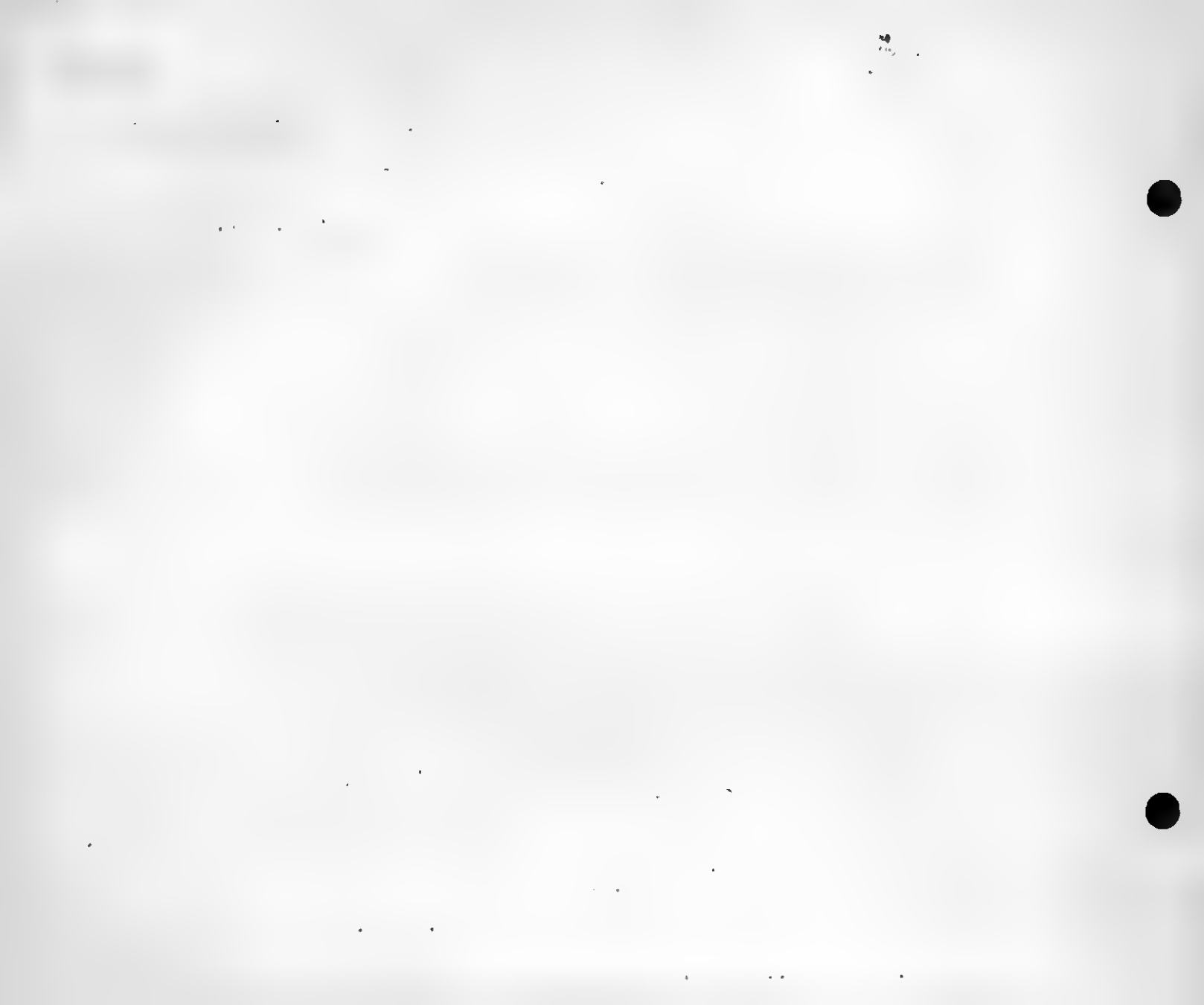
05743

Item # 3, infor. taken from birth cert.

1 PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 2hrs. 41mins d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville d. STREET ADDRESS 2117 Guilford Rd.: Apt. 301 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Christine First Lynn Middle Williams Last (Type or print) Baby GIRL		4 DATE OF DEATH Month April Day 18 Year 19 67	
5 SEX Female	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH April 18, 1967
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs 2 Months 41 Days 2 Hours 41 Min
11 BIRTHPLACE (County & State, or foreign country) Cheverly, Pr. Geo. Co.		12 CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Norman Allen Dwyer		14. MOTHER'S MAIDEN NAME Mary Veronica Gorman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Erythroblastosis fetalis due to Rh incompatibility DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that XX (this hospital) attended the deceased from April 18, 1967 , to April 18, 1967 , that (X) (we) last saw the deceased alive on April 18, 1967 , and that death occurred on April 18, 1967 from causes on the date stated above.			
22a. SIGNATURE Barbara Alvord, M.D.		22b. DATE SIGNED April 20, 1967	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS Prince Georges General Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE HEREOF 4/29/67	23c. NAME OF CEMETERY OR CREMATORY Prince George's Gen. Hosp.	23d. LOCATION (City or Town) (County) (State) Cheverly PG Maryland
24. FUNERAL DIRECTOR Harry W. Pugh, Jr., Admin.		25a. REC'D BY REGISTRAR MAY 2 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

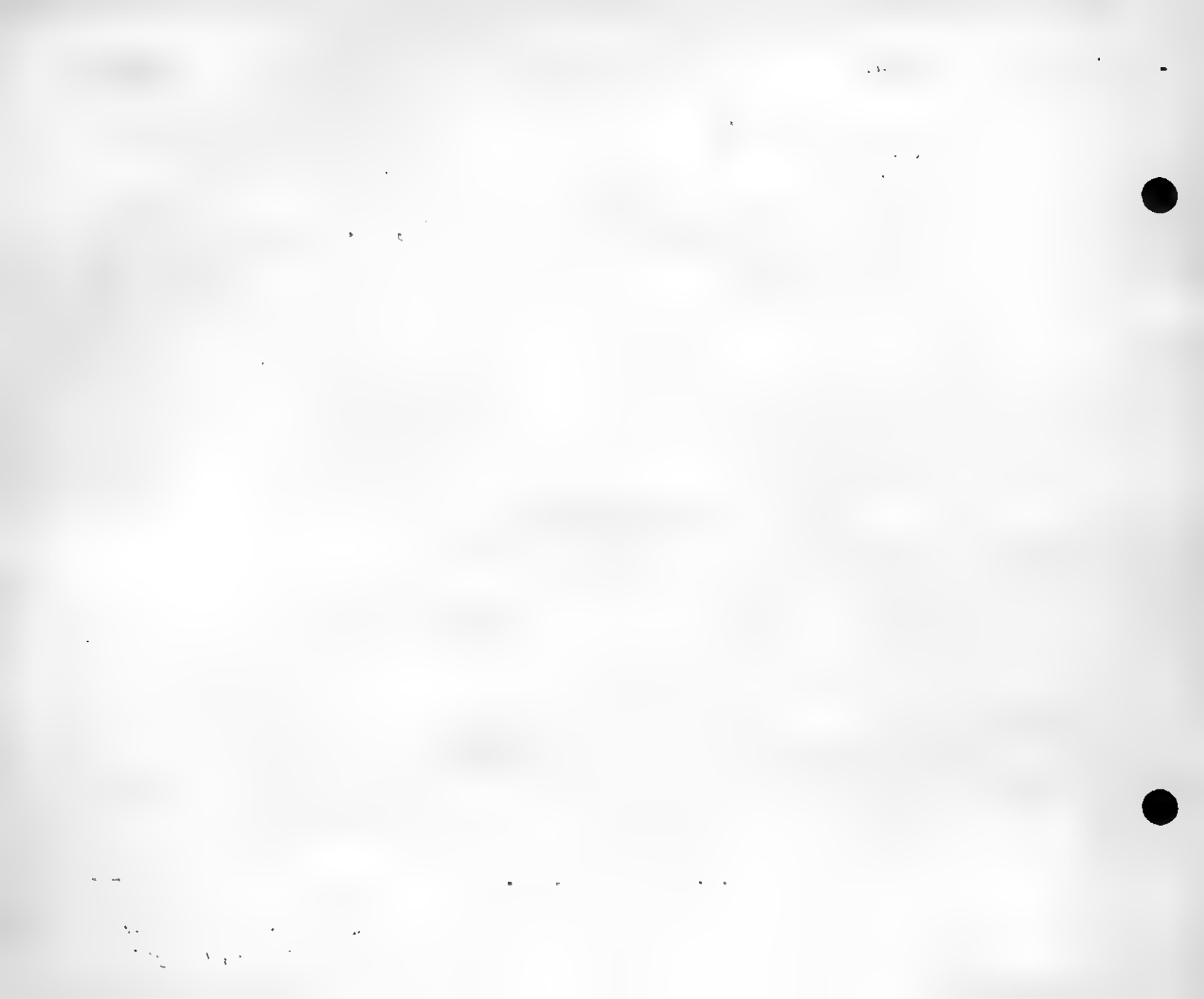
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05745

05744

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 53 hrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital		d. STREET ADDRESS Box 175, Rt. 2	
3. NAME OF DECEASED (Type or print) First Middle Last Parker J Windsor		4. DATE OF DEATH Month Day Year 4 3 19 67	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1 March 1921
9. AGE (In years last birthday) 46 yrs		10. IF UNDER 1 YEAR Months Days Hours Min. 46	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fence Installer		10b. KIND OF BUSINESS OR INDUSTRY Retail	
11. BIRTHPLACE (State or foreign country) Piscataway, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Roy Windsor		14. MOTHER'S MAIDEN NAME Edith Tayman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes WW II		16. SOCIAL SECURITY NO. 218-16-0486	
17. INFORMANT Mrs. Edith Windsor		Address Rt. 2, Box 175 Brandywine Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY a. 9 IMMEDIATE CAUSE (a) Sub-dural hematoma DUE TO And infarct of brain stem Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH Unknown		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Unknown	
20c. TIME OF INJURY Month, Day, Year Hour a.m. unknown unknown 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> unknown	20e. PLACE OF INJURY (Home farm factory, street, office bldg., etc.) unknown	20f. (City or town) (County) (State) unknown
21. I certify that I took charge of the remains described above held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Kehoe		22. DATE SIGNED 4-4-67	
EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street city town or county) 4-4-67	
23a. BURIAL, CREMATION OR REMOVAL (Specify) Burial	23b. DATE THEREOF 4-7-67	23c. NAME OF CEMETERY OR CREMATORY St. Marys cem.	23d. LOCATION (City or Town) (County) (State) Piscataway Prince Gen Md
24. FUNERAL DIRECTOR The Hunt Funeral Home, Waldorf, Md.		25a. REC'D BY REG. STRAR APR 10 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05746

CERTIFICATE OF DEATH

05745

1 PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Washington</u> b. COUNTY <u>District of Columbia</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LANHAM, Md.</u>				c. LENGTH OF STAY IN 1b <u>Washington, D.C.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>MAGNOLIA GARDENS NURSING HOME</u>				d. STREET ADDRESS <u>629 7th Person St. N.E.</u>			
3 NAME OF DECEASED (Type or print) <u>MATTIE PEARL WOODARD</u>				4 DATE OF DEATH Month <u>April</u> Day <u>25</u> Year <u>1967</u>			
5 SEX <u>F</u>		6 COLOR OR RACE <u>W</u>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>4/14/1895</u>	
9. AGE (in years last birthday) <u>72</u> yrs		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Practical Nurse</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Pvt. Duty</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Lynch Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13 FATHER'S NAME <u>Frank Shenk</u>				14. MOTHER'S MAIDEN NAME <u>Unknown at this time</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>				16 SOCIAL SECURITY NO <u>no</u>		17. INFORMANT <u>Mr. Anos Eble</u> Address <u>629 7th Person St. N.E.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> DUE TO _____ (b) _____ DUE TO _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at <u>7:00</u> A.M., from causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4/25/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>[Signature]</u>				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>4/27/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Beulahs Chapel Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Lynch Virginia</u>	
24 FUNERAL DIRECTOR <u>W. K. Humbertmann & Son</u>				ADDRESS <u>5732 Georgia Ave N.W.</u> <u>Washington, D.C.</u>		25a. REC'D BY REGISTRAR <u>APR 28 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			



1
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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05747

CERTIFICATE OF DEATH

05746

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 3 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS Box 2352	
3. NAME OF DECEASED (Type or print) First Cecelia Middle E. Last Yarbrough		4. DATE OF DEATH Month April Day 8 Year 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/12/95
9. AGE (In years last birthday) yrs. 71		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarct 578X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Severe anemia DUE TO (c) G I bleeding			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan. 1967 to Apr. 1967 , that (I) (we) last saw the deceased alive on 4/7 19 67 and that death occurred at 2:30 AM , from causes and on the date stated above.			
22a. SIGNATURE A. Clark Holmes, M. D.		22b. DATE SIGNED 4/8/67	
22c. PHYSICIAN'S NAME (Type) A. Clark Holmes, M. D.		22d. ADDRESS 4108 Pratt St., Upper Marlboro, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 4/10/67	23c. NAME OF CEMETERY OR CREMATORY Johns Hopkins School of Med. Baltimore, Md.	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR ADDRESS		25a. REC'D BY REGISTRAR DATE APR 13 1967	25b. REGISTRAR'S SIGNATURE J. Charles Judge

34520

2252

CERTIFICATE OF DEATH

05748

05747

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 4 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore Bowie d. STREET ADDRESS Tanglewood, Zug Road e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Marjorie Zug		4. DATE OF DEATH Month April Day 18 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/31/76
9. AGE (In years lost birthday) 90 yrs.		10. BIRTHPLACE (County & State, or foreign country) Washington D. C.	
11. BIRTHPLACE (County & State, or foreign country) Washington D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Edgar Zug		14. MOTHER'S MAIDEN NAME Frances Ege	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 215 54 4718	
17. INFORMANT Frances Ann Zug Stokes		18. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sarcho enteritis acute DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 6 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19 60 , to April 18, 1967 , that (I) (was) lost saw the deceased alive on April 18, 1967 , and that death occurred at 7:45 AM from causes and on the date stated above.			
22a. SIGNATURE Robert S. McCeney		22b. DATE SIGNED April 18, 1967	
22c. PHYSICIAN'S NAME (Type) Robert S. McCeney, M.D.		22d. ADDRESS 402 Main Street, Laurel, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4/21/67	23c. NAME OF CEMETERY OR CREMATORY Holy Trinity Church	23d. LOCATION (City or Town) (County) (State) Collington P. G. Md.
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR APR 24 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

